COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU
QUALITY IMPROVEMENT DIVISION

QUALITY IMPROVEMENT WORK PLAN EVALUATION REPORT FOR CALENDAR YEAR 2011
AND
QUALITY IMPROVEMENT WORK PLAN FOR CALENDAR YEAR 2012

Executive Summary

March 2012

Marvin J. Southard, D.S.W.
Director

The Quality Improvement Annual Work Plan of the Quality Improvement Division is organized into six (6) major domains, which include: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Goals, Continuity of Care, and Provider Appeals. Each domain is designed to address service needs and the quality of services provided. The Quality Improvement Program is a customer focused program dedicated to fostering consumer focused culturally competent services and improving access to underserved populations.

The total population of the County of Los Angeles is 9,818,605 people and is one of the most ethnically diverse in the nation. The distribution by ethnicity is: Latinos at 47.7%, Whites at 27.9%, Asian and Pacific Islanders at 13.7%, African Americans at 8.3%, Multi-Race at 2.2% and Native Americans at 0.2%. During FY 2010-2011, the Department provided mental health services in the eight Service Areas to approximately 220,409 persons in outpatient Short Doyle/Medi-Cal facilities that included adults and older adults with Serious Mental Illness (SMI), and children and youth with Serious Emotional Disturbance (SED).

In 2011 LACDMH collaborated with the UCLA, Integrated Substance Abuse Programs (ISAP) to pilot an abbreviated (7-item) version of the MHSIP Consumer Outcomes Survey. Goals of this initiative are to allow LACDMH to transition to a new and meaningful data collection methodology ensuring randomized representative sampling, a cost-effective and user friendly form, and the maintenance of trend analysis of the satisfaction domains. Enhanced statistical analysis will be conducted on the effectiveness of these abbreviated forms. Consumer Outcomes Survey results will be used by the Department to guide ongoing quality improvement activities.

This report provides an overview of the QI Program, a description of the Departmental QI Initiatives, including those for integration of care. It includes the detailed demographics and estimated populations with an analysis of unmet need for services within each service area. The report details progress made in achieving the 2011 QI Work Plan Goals and contains a description of the QI Work Plan goals for CY 2012.

Departmental Bureaus and Divisions including the Emergency Outreach Bureau, Patients Rights Office, Office of the Medical Director, ACCESS Center, and Service Area Quality Improvement Committees have contributed to this report.

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TABLE OF CONTENTS

APPENDIX

- **A.** Strategic Plan
- **B.** Test Calls Report
- **C.** RC2 PIP
- **D.** Change of Provider Implementation Status Report
- **E.** Beneficiary Grievances Implementation Status Report
- **F.** Provider Directories (Available online at: http://psbqi.dmh.lacounty.gov /providerdirectory.htm
- **G**: Quality Improvement Tools (Available online at: http://psbqi.dmh.lacounty.gov/QI.htm

Tables

Figures

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR CALENDAR YEAR 2011 and QUALITY IMPROVEMENT WORK PLAN FOR 2012

Introduction

The County of Los Angeles Department of Mental Health (LACDMH) Vision is: "Partnering with clients, families and communities to create hope, wellness, and recovery". LACDMH has an ever increasing focus on outcomes, continuous quality improvement and consumer satisfaction for effective service delivery and accessibility. LACDMH also faces increasingly diverse population demographic challenges. LACDMH is successfully meeting these challenges through the implementation of the Mental Health Services Act (MHSA) Plans. These Plans are essential to the fulfillment of the Mission of: "Enriching lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency". The LACDMH Values of "Integrity, Respect, Accountability, Collaboration, Dedication, Transparency, Quality and Excellence" form the foundation for constructing client quality of life, in the communities in which they live, work and learn.

It is important to note that the goals of the "Presidents New Freedom Commission on Mental Health – Transforming Mental Health Care in America" (July 2003), the Institute of Medicine's (IOM's) "Crossing the Chasm", and the SAMHSA/CMHS, NASMHPD Research Institute (NRI) National Outcome Measures (NOM's), have served to guide the LACDMH direction and selection of Performance Outcomes and goals for improved quality. This national perspective has provided a valuable framework for transformation of the system through measurable indicators that were identified by consumers and other stakeholders throughout the Nation as having universal meaning and significance for improving the lives of the persons we serve.

This report is completed in compliance with the Mental Health Plan reporting requirements of the Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.440, concerning Quality Improvement.

SECTION 1

QUALITY IMPROVEMENT PROGRAM DESCRIPTION

Quality Improvement Program Structure

The Quality Improvement Division (QID) is under the administration and direction of the Program Support Bureau (PSB), Deputy Director. Within the structure of the Program Support Bureau, the QID is concerned with improving the accessibility and quality of system wide mental health services provided to eligible consumers and families. The Countywide Quality Improvement (QI) Program is guided by strategic Quality Improvement Work Plan goals and corresponding performance management activities. The QID monitors the Department's QI Program activities for effectiveness using national strategies and standards to organize, implement, and evaluate applied contributions that lead to improved quality of care and reduced disparities.

The structure and processes of the QI Program are defined in the Department's Policy and Procedure 105.1, Quality Improvement Program Policy, to ensure that the quality and accessibility of mental health services meets and exceeds local, State, and Federal requirements. The QI Program is organized and implemented in support of uniform QI functions, responsibilities and oversight for both the directly operated and contracted providers of the County's public mental health services system. The QI Program focuses on an organizational culture of continuous quality improvement that fosters wellness and recovery; reduces disparities; promotes consumer and family involvement; improves cultural competency; and integrates mental health and substance use treatment services.

The QID includes the Data Unit, which is responsible for data collection and reporting as specifically needed to comprehensively and geographically plan for mental health services and to measure performance towards goal attainment. The areas of QI performance measurement, monitoring and management that are addressed in the QI Work Plan include: capacity, accessibility, timeliness, quality, cultural competency, consumer and family satisfaction. Data analysis is used as a key tool for decision making, monitoring change and performance management to improve services and the quality of care. QI Work Groups are established as needed and QI Tools are implemented to facilitate the work of designated teams. Departmental Performance Improvement Projects (PIPs) are conducted to ensure that selected administrative and clinical processes are studied to improve performance outcomes. The QID and Data Unit also coordinate with the Department's Bureaus, Divisions and Units directly responsible for conducting related QI activities and include the: Standards & Quality Assurance Division; ACCESS Center; Patient Rights Office; Office of STATS and Informatics; Service Area QI Teams and Multidisciplinary PIP Teams.

The Departmental Countywide Quality Improvement Council (QIC) is chaired by the QID Mental Health Clinical District Chief. It is Co-Chaired by the Regional Medical Director from the Office of the Medical Director. The QID District Chief

also participates on the Southern California QIC, the Statewide QIC, and the LACDMH Strategies for Total Accountability and Total Success (STATS). The Program Head of the Cultural Competency Unit, which is a part of the Planning Division, is a standing member of the Departmental Countywide QIC and is also the Chairperson of the Departmental Countywide Cultural Competency Committee. This structure facilitates communication and collaboration for attaining the goals as set forth in the Departmental QI Work Plan and the Cultural Competency Plan to reduce disparities and improve services. Additionally, relevant Cultural Competency Committee decisions and activities are reported to the membership at each Departmental QIC Meeting.

The QI Program structure is formally integrated within several key levels of the service delivery system. The Departmental Countywide QIC meets monthly and consists of representation from each of the eight (8) Services Areas, Countywide DMH Programs and other QI stakeholders. At the Service Area level, all Service Areas have their own regular Service Area Quality Improvement Committee (SA QIC) meetings and the SA QIC Chairpersons are standing members of the Departmental Countywide QIC. Whenever possible, each Service Area has a Chairperson and Co-Chairperson or two Co-Chairpersons with one representing Directly Operated Providers and the other representing Contract Providers. The Quality Improvement Handbook, updated June 2010, is designed to be a reference for the QI structure and process providing guidelines for the functions and responsibilities of QIC members at all levels of participation.

At the provider level, all Directly Operated and Contracted Organizational Providers maintain their own Organizational QIC. In order to ensure that the QIC communication feedback loop is complete, all Service Area Organizational Providers are required to participate in their local SA QIC. This constitutes a structure supportive of effective communication between Providers and Service Area QICs, to the Quality Improvement Council, to the intended management structures and back through the system. Lastly, there is a communication loop between the SA QIC Chairperson and/or Co-Chairpersons and the respective Service Area District Chiefs and Service Area Advisory Committee (SAAC). The SAACs are comprised of consumers, family members, providers and the LACDMH staff. The SAACs provide valuable information for program planning and opportunities for program and service improvement. SAACs are a centralized venue for improved consumer/family member participation at the SA QIC level.

Quality Improvement Processes

The ultimate purpose for the design, implementation, and evaluation of the QI Program is to ensure an organizational culture of continuous self-monitoring and self-correcting quality improvement through effective strategies, best practices, and activities, at all levels of the system.

Every year, the QID works in close collaboration with DMH staff to develop and/or revise measureable QI Work Plan goals and evaluate performance management activities. The QI Work Plan is reassessed at least annually to produce the QI Work Plan Evaluation Report and to develop and/or revise the

measureable QI Work Plan goals for the following year. Most typically, dynamic processes occur continuously throughout the year guided by collected and analyzed data that require further collaboration, such as with Integrated Systems (IS) staff for data accuracy or the Cultural Competency Unit for interpreting policy or performance management. The QI Work Plan and QI Evaluation processes can be categorized into seven (7) main categories of State and Federal requirements to include: Service Delivery Capacity, Service Accessibility, Beneficiary Satisfaction, Clinical Issues, Continuity of Care, Provider Appeals, and Performance Improvement Projects.

The QID is also responsible for the formal reporting on the effectiveness of QI processes through the development and completion of the State and County Performance Outcomes Report. The County Outcomes which reflect QI measures were initiated in January 2008 at the request of the County of Los Angeles Board of Supervisors and reflect three critical domains of importance to our system. These domains are *Access to Services*, *Consumer/Family Satisfaction* and *Clinical Effectiveness*. The performance measures were selected by a representative group of stakeholders and the methodology is described in detail in the QI State & County Performance Outcomes Report dated August 2009. The report may be found online at http://psbqi.dmh.lacounty.gov/data.htm.

The Departmental Countywide QIC systematically and formally exchanges quality improvement information, data, and performance updates on QI goals and Performance Improvement Projects. These communications are documented in QI meeting minutes, website postings, and oversight reports, as appropriate. The QI Division staff prepares updates for goal targets through Quality Improvement Work Plan Implementation Status Reports that are discussed and distributed at the Departmental QIC Meetings. These QI Reports are also shared within the SA QIC Meetings. The QI Work Plan Implementation Status Reports may be found online at http://psbqi.dmh.lacounty.gov/QI.htm. The Departmental QI Program also engages and supports the SA QICs in QI processes related to the QI Work Plan, specific PIP activities, and other QI projects conducted at the SA level. In turn, SA QICs provide a structured forum for the identification of QI opportunities that are designed specifically to address the challenges and barriers encountered at the SA level and that may exist as a priority within the SA. SA QICs also engage and support Organizational QICs that are focused on their internal Organizational QI Programs and activities. The Organizational QICs conduct internal monitoring to ensure performance standards are met consistent with Quality Assurance and Quality Improvement standards. This includes activities such as: client record reviews, identifying clinical issues, and client service satisfaction surveys.

Quality Improvement Integration

The QID is ultimately responsible for assessing and promoting Quality Improvement with respect to the domains outlined above, however, it should be noted that concurrent Quality Improvement processes and projects are occurring continuously and simultaneously throughout the LACDMH system. Not all QI Projects and initiatives of the Department are included in the QI Work Plan; nor is

it feasible to do so. An example of one such quality improvement activity is CalMEND, which is a significant pilot project with promising results in the improvement of service quality and access. In what follows, some of these other significantly effective Quality Improvement initiatives are presented.

Care Integration Collaborative

The LACDMH, PSB, QID is participating with the California Institute of Mental Health (CiMH) in the Care Integration Collaborative to improve the quality and integration of care for persons with serious and co-occurring mental health, physical health, and/or substance use disorders. This pilot collaborative brings together seven participating counties: Los Angeles, Merced, Napa, Nevada, Orange, Riverside and San Francisco. The structure of this pilot collaborative is based on the Institute for Health Care Improvement (IHI) Breakthrough Series (BTS) Learning Collaborative Model. Over a twelve month period, county partnership teams will test and make changes to achieve better health status for the identified target population. Persons in the target population are expected to have a care plan that reflects key health goals for the individual and his/her providers. This care plan should document agreements on overall care as well as progress toward planned goals. In this collaborative, care coordination occurs through cross-disciplinary clinical care coordination teams that provide or arrange care for persons in the target populations. For the duration of this collaboration, the rapid cycle improvement strategies of Plan, Do, Study and Act (PDSA) will be implemented to address the challenges of integrated care, especially as related to the Medi-Cal 1115 Waiver. Additionally, this collaboration provides an opportunity to participate within the structure of a quality Performance Improvement Project (PIP) for administrative process improvements as well as clinical improvements (See HWLA below).

STATS

The STATS (Strategies for Total Accountability and Total Success) process involves structured monthly meetings that are chaired by the Chief Deputy Director, with active participation by the Executive Management Team (EMT), District Chiefs and Program Heads. Office of STATS analysts conduct a preliminary analysis of performance indicators relative to established targets or benchmarks and prepares an agenda and questions to help focus the formal session. During the STATS meetings, the EMT reviews relevant performance data and, as necessary, strategizes with clinical program and administrative managers to develop specific action plans designed to improve performance. Follow-up is an integral part of the process, with program-specific reports provided to monitor follow-through on action plan commitments and to measure performance improvement over time.

At its inception in May 2007, the DMH STATS process focused on three core operational process metrics:

- **Direct Services** – Percent of staff time spent on direct services.
- **Benefits Establishment** – Percentage of clients with benefits.
- **Claims Lag Time** – Percentage of claims entered within 14 days of date of service.

Since that time, the following indicators have been introduced to the STATS process and are reviewed at the monthly meetings:

- **Medi-Cal Approval Percent Indicator** and **Medi-Cal Revenue Capture**. These indicators help assure that an improvement in timeliness of claim submission doesn't come at the cost of quality of data entry and revenue capture.
- **Post-Hospitalization Outpatient Service Access Indicator**. Facilitates linking clients to outpatient services within seven days after discharge from the hospital.
- **Quality Assurance (QA) Claiming Indicator**. Indicator to assure that QA programs are in place to assure regulatory accountability and compliance. This has resulted in previously unrealized revenue capture.
- **Full Service Partnership (FSP) Baseline Completion Indicator**. Monitors and enhances the completeness and quality of the FSP client's outcome data.
- **Full Service Partnership Reduction in Homelessness Indicator.**
- **Claiming by Plan indicator**. Allows for high level tracking of MHSA service transformation and monitoring for claiming / service delivery anomalies.
- **Co-Morbid Substance Abuse (Dual Diagnosis) Assessment Indicator**.
- Indicators tracking centralized Administrative Support functions including Timeliness of (1) **Rendering Provider Processing** (CIOB), (2) **Certification List Request Processing** (Human Resources) and (3) **Performance Evaluation Completion** (Executive Management Team).
- **Indigent Medication Program**

For each metric, data is aggregated at the department level, by Service Area and by individual programs. Programs are measured against specific targets, which are established by LACDMH, as well as against their peers. The STATS program also provides extensive didactic and lab-based training, mentoring, as well as numerous supplemental reports in order to enhance the skills and ability of managers and supervisors to use data to help monitor and improve their programs.

As each metric has been introduced to the STATS process, substantial performance improvements have been noted in every relevant operational or clinical domain. Examples include: a 16% increase in staff Direct Service levels and 18% increase in claim submission timeliness over the first 2 years; an increase in annual revenues of approximately $3 million / year; and an 14% increase (to 99%) of consumers showing clear evidence of assessment for co-morbid substance abuse in the first ten months since introduction of that metric.

The Executive Dashboard Committee is currently working on the further development of indicators and supporting reports and tools related to outcomes among clients served in Field Capable Clinical Service programs, mandatory

closure of cases after 150 days without consumer receiving billable services, and service access timeliness.

Model for Improving Client Service Capacity (ICSC)
In January 2010, a workgroup consisting of a cohort of Adult and Older Adult Age-Group providers began participating in a learning collaborative pilot to test out strategies to increase system capacity through the use of Continuous Quality Improvement (CQI), Plan-Do-Study-Act (PDSA) cycles. The collaborative pilot included: Didi Hirsch Mental Health Center, Exodus, Heritage Clinic, and MHA LA-The Village. Over the course of five "Learning Sessions" improvements were recorded and discussed by participant teams in order to be presented at a capstone meeting, the Harvest, conducted on September 8, 2011. In this forum, participant teams publicly shared their findings; provided input on the aim and charter of the project; and created a more focused Change Package. Organizers and participating providers received consultative and technical assistance from CiMH and CalMEND, including the support of consultants with project and CQI expertise. LACDMH is further developing the ICSC project by creating a plan to spread the learning that resulted from this collaborative, as well as the CQI approach that was the hallmark of this collaborative.

MHSA Program Outcome Measures
A key component of the implementation of MHSA programs, including Evidence Based Practices (EBPs), Full Service Partnership (FSP), and Innovation Programs is the evaluation of their effectiveness in improving consumers' level of functioning (a detailed description of each of these programs is available at http://dmh.lacounty.gov/wps/portal/dmh/about_dmh/mhsa.) For each MHSA program, clinical outcome measures are used to generate electronic databases that can be analyzed at the county, Service Provider Area (SPA), and individual provider clinic level. This data is used to identify points of intervention to improve overall service delivery. For example, individual providers with outstanding outcome performance data can be used as resources for growing successful strategies for other providers.

Coordinated Service Action Teams and Referral Tracking System for Specialized Foster Care
In partnership with DCFS, LACDMH began recording and monitoring screenings and referrals to mental health providers for all children in Foster Care. New screening/referral procedures and associated documentation standards have been implemented to ensure that Foster Care children receive needed mental health services within specified timeframes. Providers provide monthly reports of their activities to create the concatenated Referral Tracking System Report, which is delivered to the County of Los Angeles Board of Supervisors on a quarterly basis.

Integrated Primary Care, Mental Health Care, and Substance Abuse Care Services - Healthy Way LA (HWLA)

On July 1, 2011 the Department of Mental Health (DMH) formally joined the Department of Health Services (DHS) for the integration of primary care, mental health care, and substance abuse care services through implementation of the Low Income Health Program (LIHP) under the 1115 Waiver Demonstration Project. The 1115 Waiver Demonstration Project is a Medicaid Demonstration Project commonly known as California's Bridge to Reform between the Centers for Medicare and Medicaid Services (CMS) and the State of California. The 1115 Waiver Demonstration Project provides the framework to federal Health Care Reform in 2014 by permitting health care coverage expansion to individuals who will become eligible for full Medi-Cal benefits in 2014. Mental health services are now a mandated component of the LIHP and are available to all individuals enrolled in Healthy Way LA who meet mental health medical necessity criteria. Los Angeles County residents between the ages of 19-64 years old, childless or non-custodial parents, and those with income at or below 133% Federal Poverty Level with a valid government issued identification and with proof of residence are eligible for enrollment into HWLA. On January 1, 2014, under new Federal health care reform eligibility criteria, it is anticipated that active members of HWLA will be automatically enrolled into Medi-Cal thus providing a bridge or seamless transition for low income members.

There are many reasons for delivering integrated primary and behavioral health care. Some of the most compelling reasons are that integrated care improves the health outcomes and life expectancy of our service population; integrated care decreases the per capita cost of healthcare; and integrated care enhances the quality of care provided to our clients.

Enrollment in HWLA is expected to continue to increase in Los Angeles County ultimately reaching between 130,000 and 150,000 adults by 2014. HWLA primary care services are delivered through a network of providers that include DHS directly operated hospitals, comprehensive health centers, and ambulatory care centers in addition to the geographically diverse system of Community Partner agencies. The mental health benefits are delivered through the existing and expanded network of DMH directly operated and contracted specialty mental health clinics, providing culturally sensitive and linguistically appropriate services for HWLA enrollees.

Mental health care may be understood as being delivered in three "tiers." Tier 1 clients are the current DMH priority population and include those with serious mental illness. Tier 2 clients are those with acute mental illness seen in primary care settings that could benefit from short term treatment and early intervention. Tier 3 clients are those seen in primary care settings who receive and desire psychiatric medication management only services that are provided by their primary care physician. HWLA new enrollees are primarily increasing the demand for Tier 2 mental health care services.

HWLA stipulates that upon referral by the primary care provider, clients will be given an appointment for mental health service within 30 business days. Referral

tracking and reporting is required monthly including the number of clients, preferred language, ethnicity, presenting problem, date of referral, date of initial appointment, and current status. Eligible clients are provided with short term mental health treatment up to 6 sessions within a 12-week period using the Mental Health Integration Program (MHIP). Three additional sessions may be obtained if necessary with an approved Treatment Authorization Request (TAR) for a maximum of 9 sessions within a 12 week period. MHIP is an evidence-based early intervention with demonstrated success in primary care – behavioral health integration. Procedures for referral to Tier 1 level of care are specified for use as necessary. The DMH Revenue Management Division (RMD) issues RMD Bulletins with instructions and information as necessary. A HWLA toolkit is available on the DMH website at: http://dmh.lacounty.gov/wps/portal/dmh

Summary

The evaluative report that follows assesses the performance outcomes identified in the County Quality Improvement Work Plan for Calendar Year 2011. The foundation for this evaluation is presented in the context of population demographics, both Countywide and by Service Area as well as other clinical and consumer satisfaction data, including trending data. Evaluation of the Quality Improvement Work Plan results in analytical findings that inform appropriate revisions to the set goals and objectives for the subsequent year.

SECTION 2

POPULATION NEEDS ASSESSMENT

The County of Los Angeles is the most populous County in the United States with a population of 9,818,605 people in CY 2010. It consists of 95 legal cities or 20% of California's cities and covers 4,084.5 square miles or 2.6% of all the land in the state of California.

In the County of Los Angeles, population density as measured by the number of people per square mile is 2,404 while the population density in the State of California is 242.

The Population by Ethnicity in the County of Los Angeles as shown in **Fig. 1** is the highest among Latinos at 47.7%, followed by Whites at 27.9%, Asian/Pacific Islanders (API) at 13.7%, African-Americans at 8.3%, Multi Race at 2.2%, and Native Americans 0.2%.

This section contains population data for the County of Los Angeles by Ethnicity, Age, and Gender collected by the US Census Bureau for the Decennial Census conducted in 2010. Data from the decennial census is used to correct estimated population from prior years. The correction to population estimates are received by counties from the California Department of Finance (DOF). LACDMH applied these corrections to population estimates between 2005 and 2009.

Methods

This section reports on data by calendar year for population and 200% Federal Poverty Level (FPL), and by fiscal year for Medi-Cal eligible population and consumers served. All the data is reported by each Service Area (SA).

Statistical analysis to test for SA differences were conducted for overall population, 200% FPL, Medi-Cal eligible population and consumers served. Due to the high overall sample size, and smaller distribution of some categories within each SA, such as Native American or Older Adult populations, all chi-square statistics for data between SAs is statistically significant. Therefore it is not reported in each table. For additional information on SA differences, further analysis needs to be conducted separately within each SA.

The data include: Estimated Prevalence by age group for Serious Emotional Disturbance (SED) in Children and Youth and Serious Mental Illness (SMI) in Adults and Older Adults among the Total Population; Estimated Prevalence of persons with SED/SMI by Ethnicity and Gender; Estimated Population living at or below 200% FPL; and, Estimated Prevalence of persons with SED/SMI living at or below 200% FPL. These data sets together with demographic County Medi-Cal Enrollment Rates and demographic data for Consumers Served by the LACDMH provide a basic foundation for estimating target population needs.

The Service Area Estimated Prevalence Rates for persons with SED/SMI are derived by using Countywide Estimated Prevalence Rates as established and

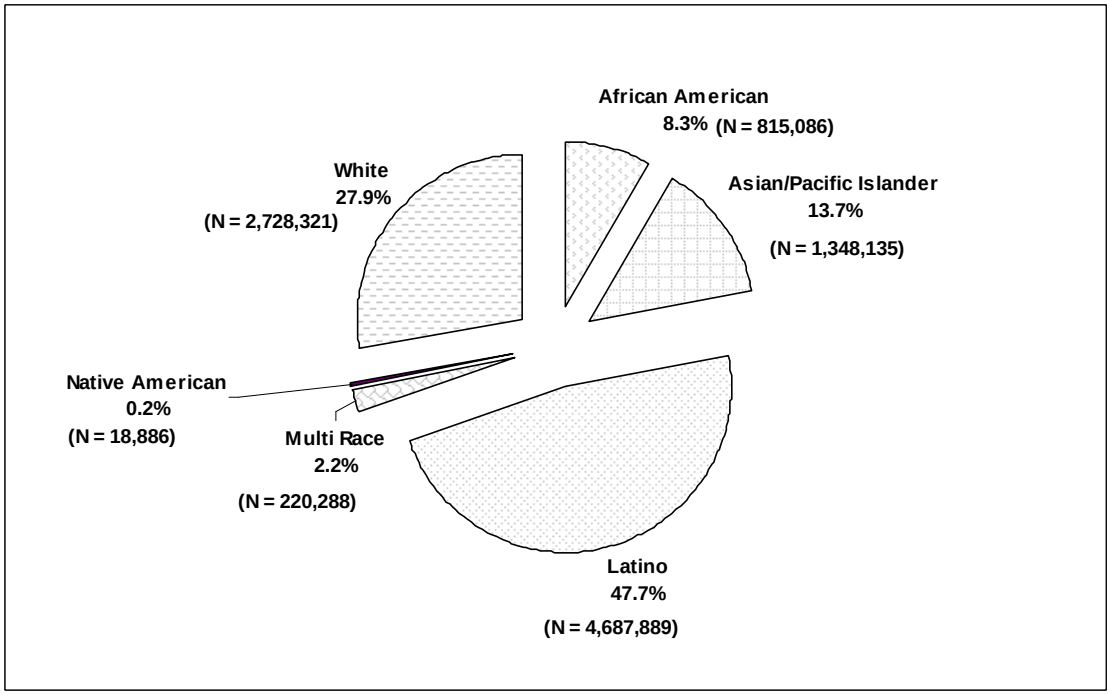
provided by the California Department of Mental Health (CDMH) and are shown in the Tables and Figures of this report. Estimated Penetration Rates for persons with SED/SMI and Estimated Retention Rates for persons with SED/SMI are derived by using demographic data for Consumers Served as compared with the Estimated Prevalence Rates as shown in the Tables and Figures of this report. Taken altogether and in consideration of other pertinent variables, this data composite is helpful in understanding and estimating target population needs.

The use of trending analysis is another means to further understand and assess target population needs. Capturing directional change over time and testing for significance are important steps in the evaluation of performance and to ensure appropriate future planning and decision making. As such, trending data and tables are also included in this report as appropriate for selected performance measures.

Additionally, the 1115 Waiver implemented during 2011 provides funding that expands the provision of mental health services to currently non-eligible Med-Cal adults living at or below the 133% FPL that meet the required enrollment eligibility criteria. The impact of Healthcare Reform, and the 133% FPL expansion of services from the 200% FPL, is significant for the enhanced provision of integrated physical health, mental health, and substance abuse services. To more accurately assess demographic and geographic population needs, the 133% FPL data is computed in a separate detailed report, produced by the LACDMH Program Support Bureau, Quality Improvement Division. This supplemental report is the “Demographic Needs Assessment Report.”

Total Population

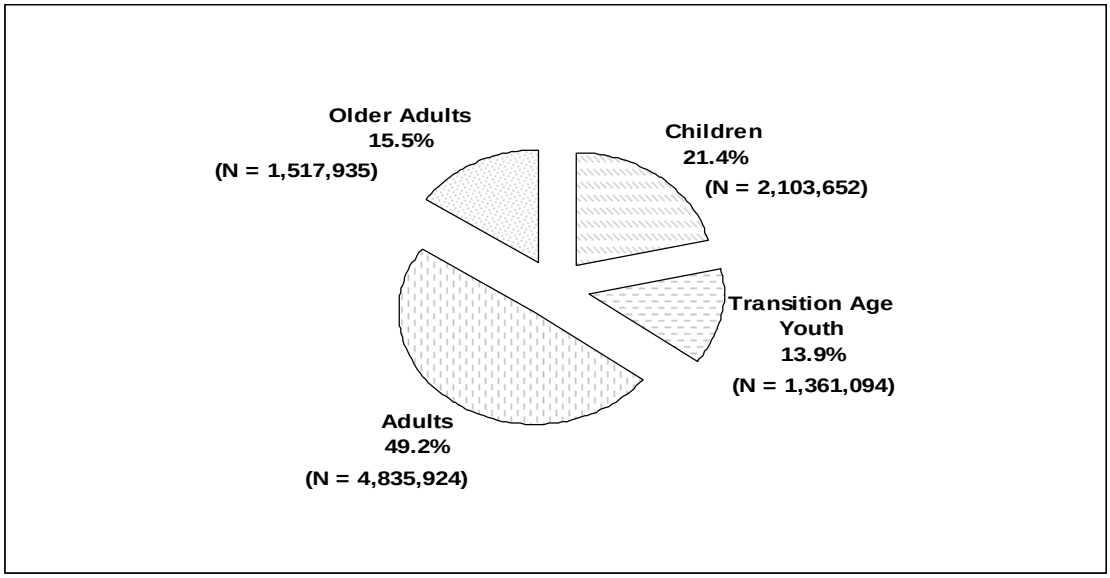
FIGURE 1: POPULATION BY ETHNICITY
CY 2010



Data Source: US Census Bureau, 2011

As shown in **Fig. 2**, Population by Age Group is the highest among Adults at 49.2%, followed by Children at 21.4%, Older Adults at 15.5%, and Transition Aged Youth (TAY) at 13.9%.

FIGURE 2: POPULATION BY AGE GROUP
CY 2010



Data Source: US Census Bureau, 2011

TABLE 1: POPULATION BY ETHNICITY AND SERVICE AREA - CY 2010

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Multi - Race	Native American	White	Service Area Total
SA 1	56,621	14,695	170,079	10,723	1,564	130,883	384,565
Percent	14.7%	3.8%	44.2%	2.8%	**0.41%**	34.0%	**3.9%**
SA 2	72,782	230,199	828,127	57,183	3,820	932,048	2,124,159
Percent	3.4%	10.8%	39.0%	0.0	0.18%	43.9%	**21.6%**
SA 3	62,836	474,512	801,804	32,019	2,935	369,414	1,743,520
Percent	3.6%	**27.2%**	46.0%	1.8%	0.17%	21.2%	17.8%
SA 4	59,014	190,570	575,290	21,510	2,051	268,073	1,116,508
Percent	5.3%	17.1%	51.5%	1.9%	0.18%	24.0%	11.4%
SA 5	35,530	80,818	99,778	26,287	950	391,383	634,746
Percent	5.6%	12.7%	**15.7%**	**4.1%**	0.15%	**61.7%**	6.5%
SA 6	275,120	17,777	667,161	13,232	1,419	24,016	998,725
Percent	**27.5%**	**1.8%**	66.8%	1.3%	**0.14%**	**2.5%**	10.2%
SA 7	36,597	112,394	947,095	14,886	2,636	180,713	1,294,321
Percent	**2.8%**	8.7%	**73.2%**	**1.2%**	0.20%	14.0%	13.2%
SA 8	216,586	227,170	598,555	44,448	3,511	431,791	1,522,061
Percent	14.2%	14.9%	39.3%	2.9%	0.23%	28.4%	15.5%
Total	815,086	1,348,135	4,687,889	220,288	18,886	2,728,321	9,818,605
Percent	8.3%	13.7%	47.7%	2.2%	0.20%	27.9%	100.0%

Note: Bold represents the highest and lowest percent in each group.
Data Source: US Census Bureau, 2011.

Differences by Ethnicity

SA 6 at 27.5% has the highest percent of African Americans as compared with the lowest percent in SA 7 at 2.8%.

SA 3 at 27.2% has the highest percent of Asian/Pacific Islanders (API) as compared with the lowest percent in SA 6 at 1.8%.

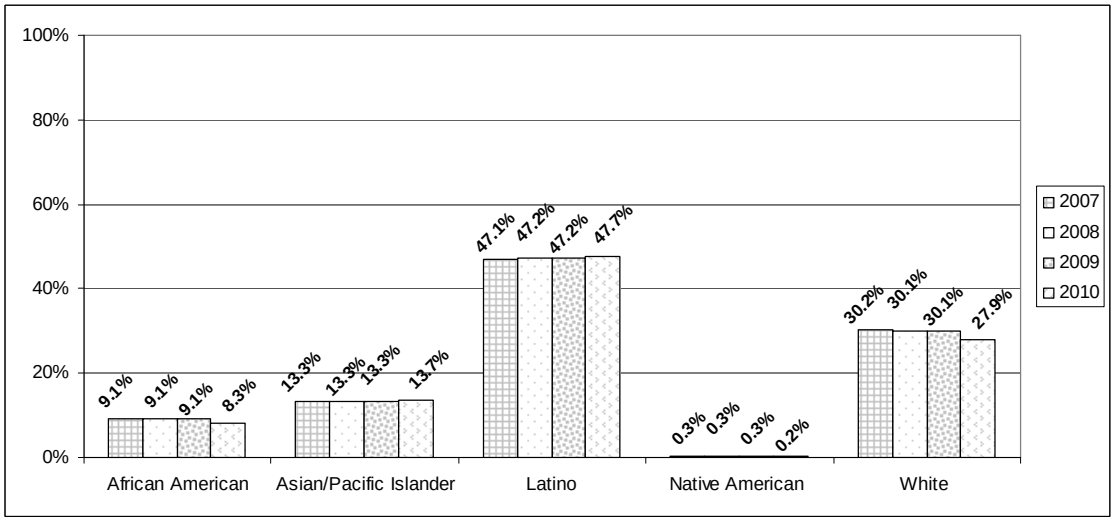
SA 7 at 73.2% has the highest percent of Latinos as compared with the lowest percent in SA 5 at 15.7%.

SA 5 at 4.1% has highest percent of Multi Race as compared with the lowest percent in SA 7 at 1.2%.

SA 1 at 0.41% has the highest percent of Native Americans as compared with the lowest percent in SA 6 at 0.14%.

SA 5 at 61.7% has highest percent of Whites as compared with the lowest percent in SA 6 at 2.5%.

FIGURE 3: POPULATION BY ETHNICITY
CY 2007 - 2010



The African American population decreased by 0.8% from 9.1% in 2007 to 8.3% in 2010.

The Asian/Pacific Islander (API) population increased by 0.4% from 13.3% in 2007 to 13.7% in 2010.

The Latino population increased by 0.6% from 47.1% in 2007 to 47.7% in 2010.

The Native American population decreased by 0.1% from 0.3% in 2007 to 0.2% in 2010.

The White population decreased by 2.3% from 30.2% in 2007 to 27.9% in 2010.

TABLE 2: POPULATION BY AGE GROUP AND SERVICE AREA - CY 2010

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60+ yrs	SA Total
SA 1	101,814	58,656	177,074	47,021	384,565
Percent	26.5%	15.3%	46.0%	12.2%	**3.9%**
SA 2	436,168	273,530	1,071,048	343,413	2,124,159
Percent	20.5%	**12.9%**	50.4%	16.2%	**21.6%**
SA 3	361,440	238,157	839,308	304,615	1,743,520
Percent	20.7%	13.7%	48.1%	17.5%	17.8%
SA 4	195,951	147,433	609,148	163,976	1,116,508
Percent	17.6%	13.2%	**54.6%**	14.7%	11.4%
SA 5	88,722	85,087	336,291	124,646	634,746
Percent	**14.0%**	13.4%	53.0%	**19.6%**	6.5%
SA 6	272,792	169,513	448,929	107,491	998,725
Percent	**27.3%**	**17.0%**	**45.0%**	**10.8%**	10.2%
SA 7	316,356	191,258	602,516	184,191	1,294,321
Percent	24.4%	14.8%	46.6%	14.2%	13.2%
SA 8	330,409	197,460	751,610	242,582	1,522,061
Percent	21.7%	13.0%	49.4%	15.9%	15.5%
Total	2,103,652	1,361,094	4,835,924	1,517,935	9,818,605
Percent	21.4%	13.9%	49.2%	15.5%	100.0%

Note: Bold represents the highest and lowest percent in each group.
Data Source: US Census Bureau, 2011.

Differences by Age Group

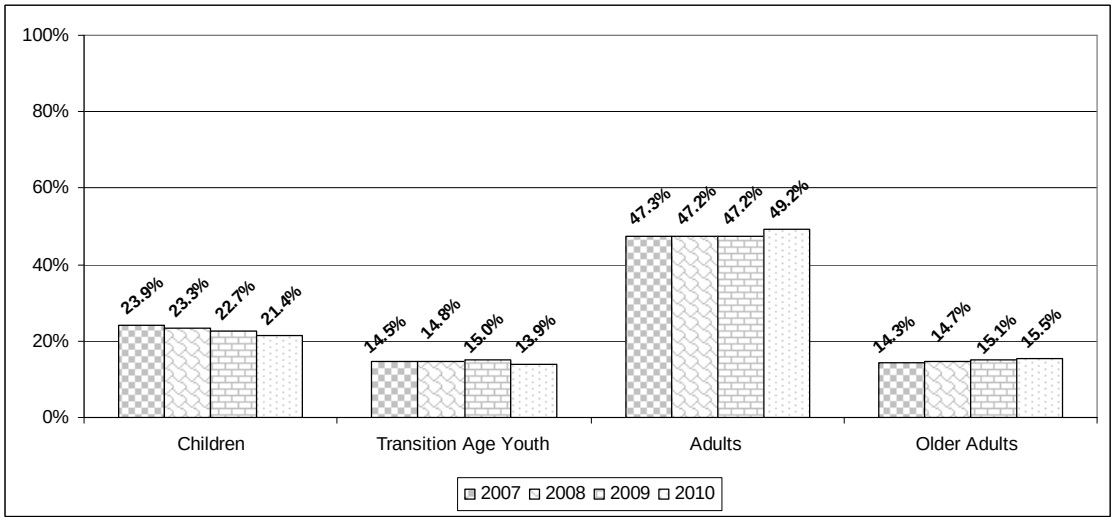
SA 6 at 27.3% has the highest percent of Children as compared with the lowest percent in SA 5 at 14.0%.

SA 6 at 17.0% has the highest percent of TAY as compared with the lowest percent in SA 2 at 12.9%.

SA 4 at 54.6% has the highest percent of Adults as compared with the lowest percent in SA 6 at 45.0%.

SA 5 at 19.6% has the highest percent of Older Adults as compared with the lowest percent in SA 6 at 10.7%.

FIGURE 4: POPULATION BY AGE GROUP
CY 2007 - 2010



Children decreased by 2.5% from 23.9% in 2007 to 21.4% in 2010.

TAY decreased by 0.6% from 14.5% in 2007 to 13.9% in 2010, although increased to up to 15.0% in 2009.

Adults increased by 1.9% from 47.3% in 2007 to 49.2% in 2010.

Older Adults increased by 1.2% from 14.3% in 2007 to 15.5% in 2010.

TABLE 3: POPULATION BY GENDER AND SERVICE AREA - CY 2010

Service Area (SA)	Male	Female	SA Total
SA 1	191,152	193,413	384,565
Percent	49.7%	50.3%	3.9%
SA 2	1,050,866	1,073,293	2,124,159
Percent	49.5%	50.5%	21.6%
SA 3	850,450	893,070	1,743,520
Percent	48.8%	51.2%	17.8%
SA 4	574,135	542,373	1,116,508
Percent	**51.4%**	**48.6%**	11.4%
SA 5	307,300	327,446	634,746
Percent	**48.4%**	**51.6%**	6.5%
SA 6	485,639	513,086	998,725
Percent	48.6%	51.4%	10.2%
SA 7	635,632	658,689	1,294,321
Percent	49.1%	50.9%	13.2%
SA 8	744,480	777,581	1,522,061
Percent	48.9%	51.1%	15.5%
Total	4,839,654	4,978,951	9,818,605
Percent	49.3%	50.7%	100.0%

Note: Bold represents the highest and lowest percent in each group.
Data Source: US Census Bureau, 2011.

Differences by Gender

SA 4 at 51.4% has the highest percent of Males as compared with the lowest percent in SA 5 at 48.4%.

SA 5 has the highest percent of Females at 51.6% as compared with the lowest percent in SA 4 at 48.6%.

TABLE 4: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG TOTAL POPULATION BY ETHNICITY AND SERVICE AREA - CY 2010

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White
SA 1	3,963	720	11,906	125	7,853
Percent	16.1%	2.9%	48.5%	**0.50%**	32.0%
SA 2	5,095	11,280	57,969	306	55,923
Percent	3.9%	8.6%	44.4%	0.32%	42.8%
SA 3	4,399	23,251	56,126	235	22,165
Percent	4.1%	**21.9%**	52.9%	0.22%	20.9%
SA 4	4,131	9,338	40,270	164	16,084
Percent	5.9%	13.4%	57.5%	0.2%	23.0%
SA 5	2,487	3,960	6,984	76	23,483
Percent	6.7%	10.7%	**18.9%**	0.23%	**63.5%**
SA 6	19,258	871	46,701	114	1,441
Percent	**28.2%**	**1.3%**	68.3%	**0.16%**	**2.0%**
SA 7	2,562	5,507	66,297	211	10,843
Percent	**3.0%**	6.4%	**77.6%**	0.24%	12.8%
SA 8	15,161	11,131	41,899	281	25,907
Percent	16.1%	11.8%	44.4%	0.30%	27.4%
Total	57,056	66,058	328,152	1,512	163,699
Percent	9.3%	10.7%	53.2%	0.24%	26.6%

Note: Bold represents the highest and lowest percent in each group.

[1] SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by California State Department of Mental Health for total population at 5.36%. The rate varies by ethnic groups at 4.9% for API and 8.0% for Native Americans.

Differences by Ethnicity

SA 6 at 28.2% has the highest percent of African Americans estimated with SED and SMI as compared to the lowest in SA 7 at 3.0%.

SA 3 at 21.9% has the highest percent of Asian/Pacific Islanders (API) estimated with SED and SMI as compared to the lowest in SA 6 at 1.3%.

SA 7 at 77.6% has the highest percent of Latinos estimated with SED and SMI as compared to the lowest in SA 5 at 18.9%.

SA 1 at 0.50% has the highest percent of Native Americans estimated with SED and SMI as compared to the lowest in SA 6 at 0.16%.

SA 5 at 63.5% has the highest percent of Whites estimated with SED and SMI as compared to the lowest in SA 6 at 2.0%.

TABLE 5: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG TOTAL POPULATION BY AGE GROUP AND SERVICE AREA - CY 2010

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60+ yrs
SA 1	8,145	2,933	9,031	1,129
Percent	38.4%	13.8%	42.5%	5.3%
SA 2	34,893	13,677	54,623	8,242
Percent	31.3%	**12.3%**	49.0%	7.4%
SA 3	28,915	11,908	42,805	7,311
Percent	31.8%	13.1%	47.1%	8.0%
SA 4	15,676	7,372	31,067	3,935
Percent	27.0%	12.7%	53.5%	6.8%
SA 5	7,098	4,254	17,151	2,992
Percent	**22.5%**	13.5%	**54.5%**	**9.5%**
SA 6	21,823	8,476	22,895	2,580
Percent	**39.1%**	**15.3%**	**41.0%**	**4.6%**
SA 7	25,308	9,563	30,728	4,421
Percent	36.1%	13.7%	43.9%	6.3%
SA 8	26,433	9,873	38,332	5,822
Percent	32.9%	**12.3%**	47.6%	7.2%
Total	168,291	68,056	246,632	36,432
Percent	32.4%	13.1%	47.5%	7.0%

Note: Bold represents the highest and lowest percent in each group.
[1] SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by California State Department of Mental Health for total population at 5.36%. The rate varies for age-groups at 2.4% for older adults and 8.0% for children.

Differences by Age Group

SA 6 at 39.1% has the highest percent of Children estimated with SED and SMI as compared with the lowest in SA 5 at 22.5%.

SA 6 at 15.3% has the highest percent of TAY estimated with SED and SMI as compared with the lowest in SA 8 at 12.3%.

SA 5 at 54.5% has the highest percent of Adults estimated with SED and SMI as compared with the lowest in SA 6 at 41.0%.

SA 5 at 9.5% has the highest percent of Older Adults estimated with SED and SMI as compared with the lowest in SA 6 at 4.6%.

TABLE 6: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG TOTAL POPULATION BY GENDER AND SERVICE AREA - CY 2010

Service Area (SA)	Male	Female
SA 1	11,469	12,572
Percent	47.7%	52.3%
SA 2	63,052	69,764
Percent	47.5%	52.5%
SA 3	51,027	58,050
Percent	46.8%	53.2%
SA 4	34,448	35,254
Percent	**49.4%**	**50.6%**
SA 5	18,438	21,284
Percent	**46.4%**	**53.6%**
SA 6	29,138	33,351
Percent	46.6%	53.4%
SA 7	38,138	42,815
Percent	47.1%	52.9%
SA 8	44,669	50,543
Percent	46.9%	53.1%
Total	290,379	323,633
Percent	47.3%	52.7%

Note: Bold represents the highest and lowest percent in each group.

[1] SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by California State Department of Mental Health for total population at 5.36%. The rate varies for each gender at 7.6% for males and 8.0% for females.

Differences by Gender

SA 4 at 49.4% has the highest percent of Males estimated with SED and SMI as compared with the lowest in SA 5 at 46.4%.

SA 5 at 53.6% has the highest percent of Females estimated with SED and SMI as compared with the lowest in SA 4 at 50.6%.

Estimated Population Living at or Below 200% Federal Poverty Level (FPL)

TABLE 7: ESTIMATED POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY AND SERVICE AREA - CY 2010

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Service Area Total
SA 1	26,007	3,796	60,736	953	36,774	128,268
Percent	20.3%	3.0%	47.4%	**0.70%**	28.6%	3.8%
SA 2	28,162	48,954	389,563	2,108	195,968	664,755
Percent	4.2%	7.4%	58.6%	0.31%	29.5%	17.8%
SA 3	29,232	137,133	352,231	1,484	79,225	599,305
Percent	4.9%	**22.9%**	58.8%	0.25%	13.2%	16.0%
SA 4	22,373	71,468	412,838	1,189	70,865	578,733
Percent	3.9%	12.3%	71.3%	0.20%	12.3%	15.5%
SA 5	10,703	17,399	41,177	353	65,384	135,015
Percent	7.9%	12.9%	**30.5%**	0.30%	**48.4%**	3.6%
SA 6	147,978	7,005	446,199	523	7,811	609,516
Percent	**24.3%**	**1.1%**	73.2%	**0.10%**	**1.3%**	16.3%
SA 7	14,700	28,795	454,687	1,439	42,341	542,962
Percent	**2.7%**	5.5%	**83.7%**	0.30%	7.8%	14.5%
SA 8	85,784	55,300	271,947	1,148	66,986	481,165
Percent	17.8%	11.5%	56.5%	0.21%	14.0%	12.9%
Total	364,939	370,852	2,429,378	9,196	565,354	3,739,719
Percent	9.8%	9.9%	65.0%	0.25%	15.1%	100.0%

Note: Bold represents the highest and lowest percent in each group.
Data Source: US Census Bureau, 2011. 2010 poverty estimates are imputed from 2009 poverty estimates.

Differences by Ethnicity

SA 6 at 24.3% has the highest percent of African Americans living at or below 200% FPL as compared with the lowest percent in SA 7 at 2.7%.

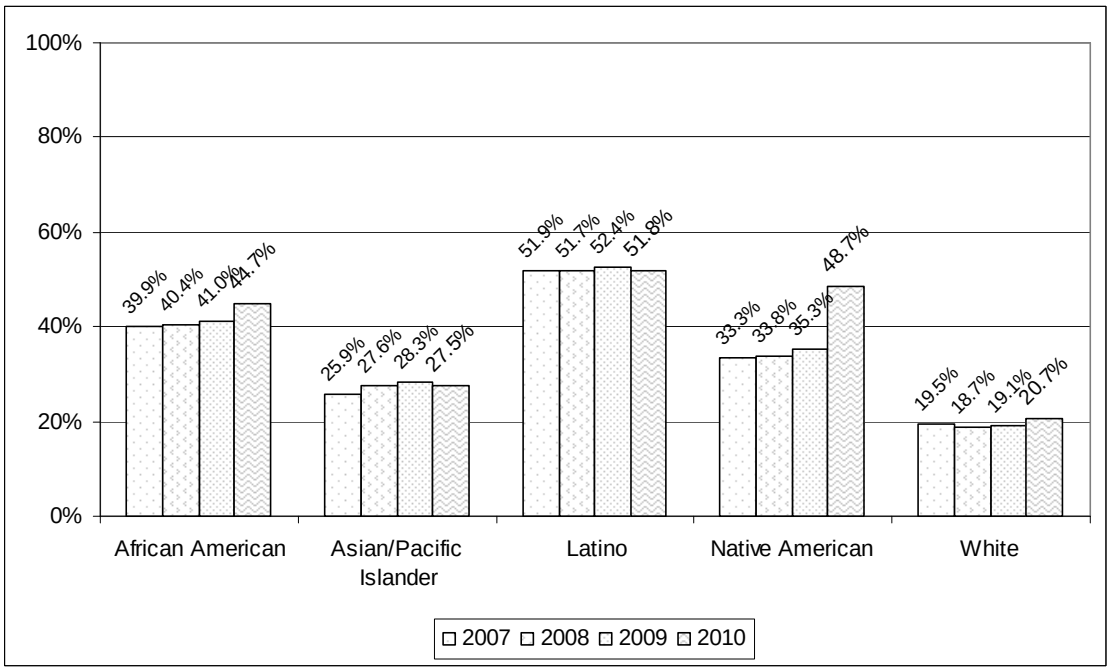
SA 3 at 22.9% has the highest percent of Asian/Pacific Islanders (API) living at or below 200% FPL as compared with the lowest percent in SA 6 at 1.1%.

SA 7 at 83.7% has the highest percent of Latinos living at or below 200% FPL as compared with the lowest percent in SA 5 at 30.5%.

SA 1 at 0.70% has the highest percent of Native Americans living at or below 200% FPL as compared with the lowest percent in SA 6 at 0.10%.

SA 5 at 48.4% has highest percent of Whites living at or below 200% FPL as compared with the lowest percent in SA 6 at 1.3%.

FIGURE 5: ESTIMATED POVERTY RATE AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY CY 2007 - 2010



Note: Estimated Poverty Rate by Ethnicity = Total population living at or below 200% FPL divided by total population in each ethnic group.

African Americans living at or below the 200% FPL show an increase of 4.8% from 39.9% in 2007 to 44.7% in 2010.

Asian/Pacific Islanders (API) living at or below the 200% FPL show an increase of 1.6% from 25.9% in 2007 to 27.5% in 2010.

Latinos living at or below the 200% FPL show a decrease of 0.1% from 51.9% in 2007 to 51.8% in 2010, although there was an increase in 2009 to 52.4%.

Native Americans living at or below the 200% FPL show an increase of 15.4% from 33.3% in 2007 to 48.7% in 2010.

Whites living at or below the 200% FPL show an increase of 1.2% from 19.5% in 2007 to 20.7% in 2010.

TABLE 8: ESTIMATED POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP AND SERVICE AREA - CY 2010

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60+ yrs	SA Total
SA 1	40,654	28,055	47,334	12,225	128,268
Percent	31.7%	**21.9%**	**36.9%**	**9.5%**	3.4%
SA 2	195,109	98,653	273,371	97,622	664,755
Percent	29.4%	14.8%	41.1%	14.7%	17.8%
SA 3	166,081	100,454	249,554	83,216	599,305
Percent	27.7%	16.8%	41.6%	13.9%	16.0%
SA 4	155,417	76,014	267,127	80,175	578,733
Percent	26.9%	13.1%	46.2%	13.8%	15.5%
SA 5	25,907	15,139	63,445	30,524	135,015
Percent	**19.2%**	**11.2%**	**47.0%**	**22.6%**	3.6%
SA 6	219,175	104,982	235,574	49,785	609,516
Percent	**36.0%**	17.2%	38.6%	8.2%	16.3%
SA 7	176,312	85,569	220,683	60,398	542,962
Percent	32.5%	15.8%	40.6%	11.1%	14.5%
SA 8	161,576	77,863	185,637	56,089	481,165
Percent	33.6%	16.2%	38.6%	11.6%	12.9%
Total	1,140,231	586,729	1,542,725	470,034	3,739,719
Percent	30.5%	15.7%	41.3%	12.5%	100.0%

Note: Bold represents the highest and lowest percent in each group.
Data Source: US Census Bureau, 2011. 2010 poverty estimates are imputed from 2009 poverty estimates.

Differences by Age Group

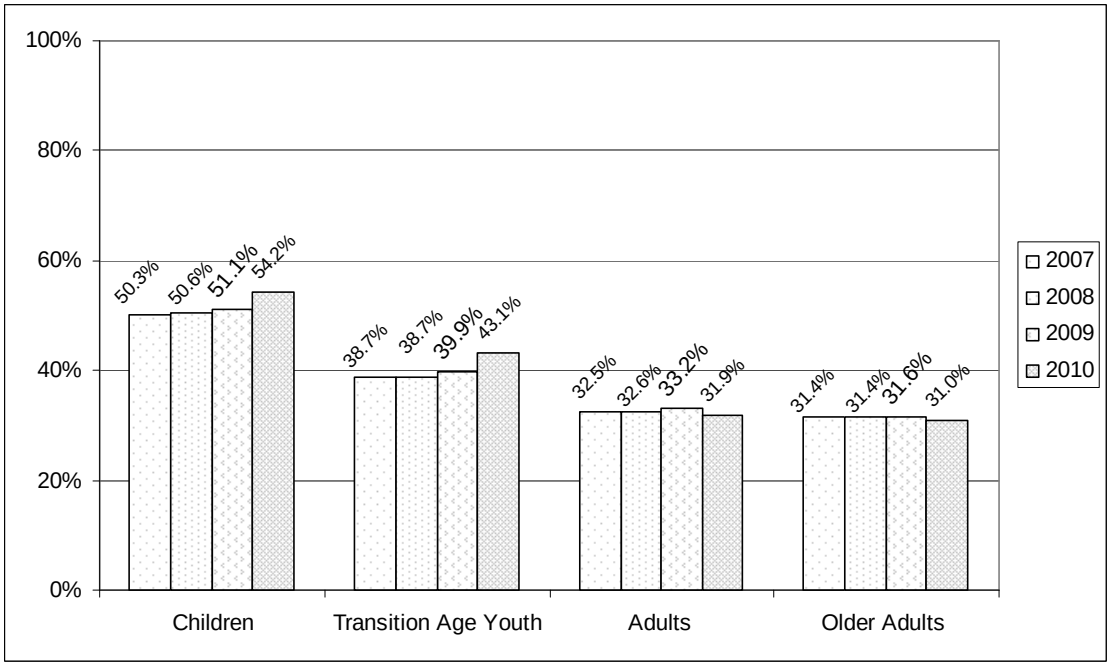
SA 6 at 36.0% has the highest percent of Children living at or below 200% FPL as compared with the lowest percent in SA 5 at 19.2%.

SA 1 at 21.9% has the highest percent of TAY living at or below 200% FPL as compared with the lowest percent in SA 5 at 11.2%.

SA 5 at 47.0% has the highest percent of Adults living at or below 200% FPL as compared with the lowest percent in SA 1 at 36.9%.

SA 5 at 22.6% has the highest percent of Older Adults living at or below 200% FPL as compared with the lowest percent in SA 1 at 9.5%.

FIGURE 6: ESTIMATED POVERTY RATE AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP CY 2007 - 2010



Note: Estimated Poverty Rate by Age Group = Total population living at or below 200% FPL divided by total population in each age group.

Children living at or below 200% Federal Poverty Level increased 3.9% from 50.3% in 2007 to 54.2% in 2010.

TAY living at or below 200% Federal Poverty Level increased 4.4% from 38.7% in 2007 to 43.1% in 2010.

Adults living at or below the 200% Federal Poverty Level decreased 0.6% from 32.5% in 2007 to 31.9% in 2010, although there was an increase to 33.2% in 2009.

Older Adults living at or below the 200% Federal Poverty Level decreased 0.4% from 31.4% in 2007 to 31.0% in 2010, although there was an increase to 31.6% in 2009.

TABLE 9: ESTIMATED POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA - CY 2010

Service Area (SA)	Male	Female	SA Total
SA 1	58,913	69,355	128,268
Percent	**45.9%**	**54.1%**	3.4%
SA 2	314,355	350,400	664,755
Percent	47.3%	52.7%	17.8%
SA 3	282,962	316,343	599,305
Percent	47.2%	52.8%	16.0%
SA 4	281,423	297,310	578,733
Percent	**48.6%**	**51.4%**	15.5%
SA 5	62,542	72,473	135,015
Percent	46.3%	53.7%	3.6%
SA 6	291,656	317,860	609,516
Percent	47.9%	52.1%	16.3%
SA 7	259,368	283,594	542,962
Percent	47.8%	52.2%	14.5%
SA 8	225,684	255,481	481,165
Percent	46.9%	53.1%	12.9%
Total	1,776,903	1,962,816	3,739,719
Percent	47.5%	52.5%	100.0%

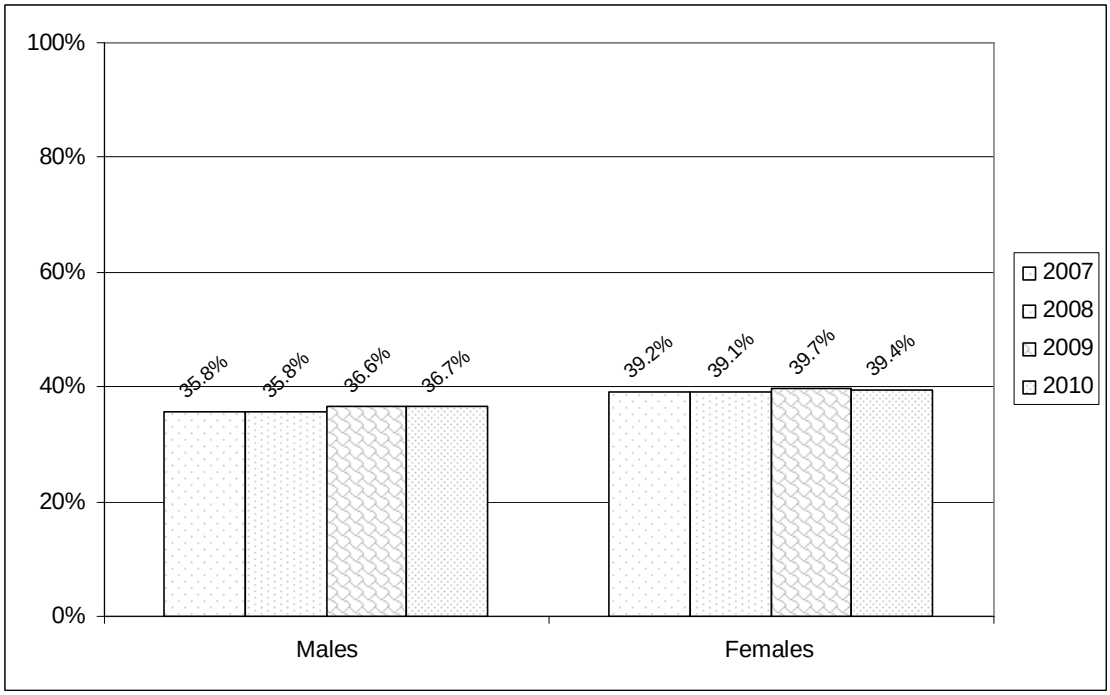
Note: Bold represents the highest and lowest percent in each group.
Data Source: US Census Bureau, 2011. 2010 poverty estimates are imputed from 2009 poverty estimates.

Differences by Gender

SA 4 at 48.6% has the highest percent of Males living at or below 200% FPL as compared with the lowest percent in SA 1 at 45.9%.

SA 1 at 54.1% has the highest percent of Females living at or below 200% FPL as compared with the lowest percent in SA 4 at 51.4%.

FIGURE 7: ESTIMATED POVERTY RATE AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY GENDER CY 2007 - 2010



Note: Estimated Poverty Rate by Gender = Total population living at or below 200% FPL divided by total population by gender.

Males living at or below 200% Federal Poverty Level increased by 0.9% from 35.8% in 2007 to 36.7% in 2010.

Females living at or below 200% Federal Poverty Level increased by 0.2% from 39.2% in 2007 to 39.4% in 2010.

TABLE 10: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY AND SERVICE AREA - CY 2010

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White
SA 1	1,821	228	4,252	70	2,317
Percent	21.0%	2.6%	48.9%	**0.81%**	26.7%
SA 2	1,971	2,937	27,269	156	12,346
Percent	4.4%	6.6%	61.0%	0.35%	27.6%
SA 3	2,046	8,228	24,656	110	4,991
Percent	5.1%	**20.6%**	61.6%	0.27%	12.5%
SA 4	1,566	4,288	28,899	88	4,464
Percent	4.0%	10.9%	73.5%	0.22%	11.4%
SA 5	749	1,044	2,882	26	4,119
Percent	8.5%	11.8%	**32.7%**	0.30%	**46.7%**
SA 6	10,358	420	31,234	39	492
Percent	**24.3%**	**1.0%**	73.4%	**0.09%**	**1.2%**
SA 7	1,029	1,728	31,828	106	2,667
Percent	**2.8%**	4.6%	**85.2%**	0.29%	7.1%
SA 8	6,005	3,318	19,036	85	4,220
Percent	18.4%	10.2%	58.3%	0.26%	12.9%
Total	25,546	22,251	170,056	681	35,617
Percent	10.1%	8.8%	66.9%	0.27%	14.0%

Note: Bold represents the highest and lowest percent in each group.

[1] SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by California State Department of Mental Health for population living at or below 200% FPL at 8.04%. The rate varies by ethnic groups at 6.7% for Asian/Pacific Islanders and 8.7% for Native Americans.

Differences by Ethnicity

SA 6 at 24.3 % has the highest percent of African Americans living at or below 200% FPL and estimated with SED and SMI as compared with the lowest in SA 7 at 2.8%.

SA 3 at 20.6% has the highest percent of Asian/Pacific Islanders (API) living at or below 200% FPL and estimated with SED and SMI as compared with the lowest in SA 6 at 1.0%.

SA 7 at 85.2% has the highest percent of Latinos living at or below 200% FPL and estimated with SED and SMI as compared to the lowest in SA 5 at 32.7%.

SA 1 at 0.81% has the highest percent of Native Americans estimated with SED and SMI as compared to the lowest in SA 6 at 0.09%.

SA 5 at 46.7% has the highest percent of Whites estimated with SED and SMI as compared to the lowest in SA 6 at 1.2%.

TABLE 11: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP AND SERVICE AREA – CY 2010

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60+ yrs
SA 1	2,753	1,900	3,206	828
Percent	31.7%	**21.9%**	36.9%	9.5%
SA 2	13,114	6,631	18,374	6,562
Percent	29.4%	14.8%	41.1%	14.7%
SA 3	11,094	6,710	16,669	5,559
Percent	27.7%	16.8%	41.6%	13.9%
SA 4	10,555	5,163	18,142	5,445
Percent	26.9%	13.1%	46.2%	13.9%
SA 5	1,693	989	4,145	1,994
Percent	**19.2%**	**11.2%**	**47.0%**	**22.6%**
SA 6	15,298	7,328	16,443	3,475
Percent	**36.0%**	17.2%	**38.6%**	**8.2%**
SA 7	12,151	5,897	15,209	4,162
Percent	32.5%	15.8%	40.6%	11.1%
SA 8	10,969	5,286	12,602	3,808
Percent	33.6%	16.2%	36.8%	11.7%
Total	77,490	39,874	104,844	31,944
Percent	30.5%	15.7%	41.3%	12.6%

Note: Bold represents the highest and lowest percent in each group.

[1] SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by California State Department of Mental Health for population living at or below 200% FPL at 8.04%. The rate varies for age-groups at 5.0% for older adults and 8.7% for children.

Differences by Age Group

SA 6 at 36.0% has the highest percent of Children living at or below 200% FPL and estimated with SED and SMI as compared to the lowest in SA 5 at 19.2%.

SA 1 at 21.9% has the highest percent of TAY living at or below 200% FPL and estimated with SED and SMI as compared to the lowest in SA 5 at 11.2%.

SA 5 at 47.0% has the highest percent of Adults living at or below 200% FPL and estimated with SED and SMI as compared to the lowest in SA 6 at 38.6%.

SA 5 at 22.6% has the highest percent of Older Adults living at or below 200% FPL and estimated with SED and SMI as compared to the lowest in SA 6 at 8.2%.

TABLE 12: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA - CY 2010

Service Area (SA)	Male	Female
SA 1	4,318	4,369
Percent	49.7%	50.3%
SA 2	22,104	22,575
Percent	49.5%	50.5%
SA 3	19,526	20,505
Percent	48.8%	51.2%
SA 4	20,212	19,094
Percent	**51.4%**	**48.6%**
SA 5	4,270	4,550
Percent	**48.4%**	**51.6%**
SA 6	20,687	21,856
Percent	48.6%	51.4%
SA 7	18,376	19,043
Percent	49.1%	50.9%
SA 8	15,977	16,687
Percent	48.9%	51.1%
Total	125,273	128,878
Percent	49.3%	50.7%

Note: Bold represents the highest and lowest percent in each group.[1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by California State Department of Mental Health for population living at or below 200% FPL at 8.04%. The rate varies by gender at 7.4% for males and 8.0% for females.

Differences Gender

SA 4 at 51.4% has the highest percent of Males living at or below 200% FPL and estimated with SED and SMI as compared with the lowest in SA 5 at 48.4%.

SA 5 at 51.6% has the highest percent of Females living at or below 200% FPL and estimated with SED and SMI as compared with the lowest in SA 4 at 48.6%.

Population Enrolled in Medi-Cal

TABLE 13: POPULATION ENROLLED IN MEDI-CAL BY ETHNICITY AND SERVICE AREA MARCH 2011

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Service Area Total
SA 1	23,827	1,928	47,957	234	17,920	91,866
Percent	25.9%	2.1%	52.2%	**0.25%**	19.5%	4.7%
SA 2	13,868	23,474	204,861	384	110,407	352,994
Percent	3.9%	6.6%	58.0%	0.11%	31.3%	**18.1%**
SA 3	14,162	79,467	194,328	387	29,259	317,603
Percent	4.5%	**25.0%**	61.2%	0.12%	9.2%	16.3%
SA 4	13,202	33,271	167,247	258	26,840	240,818
Percent	5.5%	13.8%	69.4%	0.11%	11.1%	12.4%
SA 5	5,449	2,984	15,555	86	15,935	40,009
Percent	13.6%	7.5%	**38.9%**	0.21%	**39.8%**	**2.1%**
SA 6	99,854	3,070	242,153	209	6,090	351,376
Percent	**28.4%**	**0.9%**	68.9%	**0.06%**	**1.7%**	**18.1%**
SA 7	8,229	13,203	241,533	355	17,365	280,685
Percent	**2.9%**	4.7%	**86.1%**	0.13%	6.2%	14.4%
SA 8	57,654	31,372	155,935	427	24,303	269,691
Percent	21.4%	11.6%	57.8%	0.16%	9.0%	13.9%
Total	236,245	188,769	1,269,569	2,340	248,119	1,945,042
Percent	12.1%	9.7%	65.3%	0.12%	12.8%	100.0%

Note:
1. Bold represents the highest and lowest percent in each group.
2. Data excludes Medi-Cal enrolled who are without Service Area designations (N = 90,660) or 4.05% from the total count of 2,239,690 in the State MEDS Beneficiary file.
3. Data Source: State MEDS File, March 2011.

Differences by Ethnicity

SA 6 at 28.4% has the highest percent of African Americans enrolled in Medi-Cal as compared with the lowest in SA 7 at 2.9%.

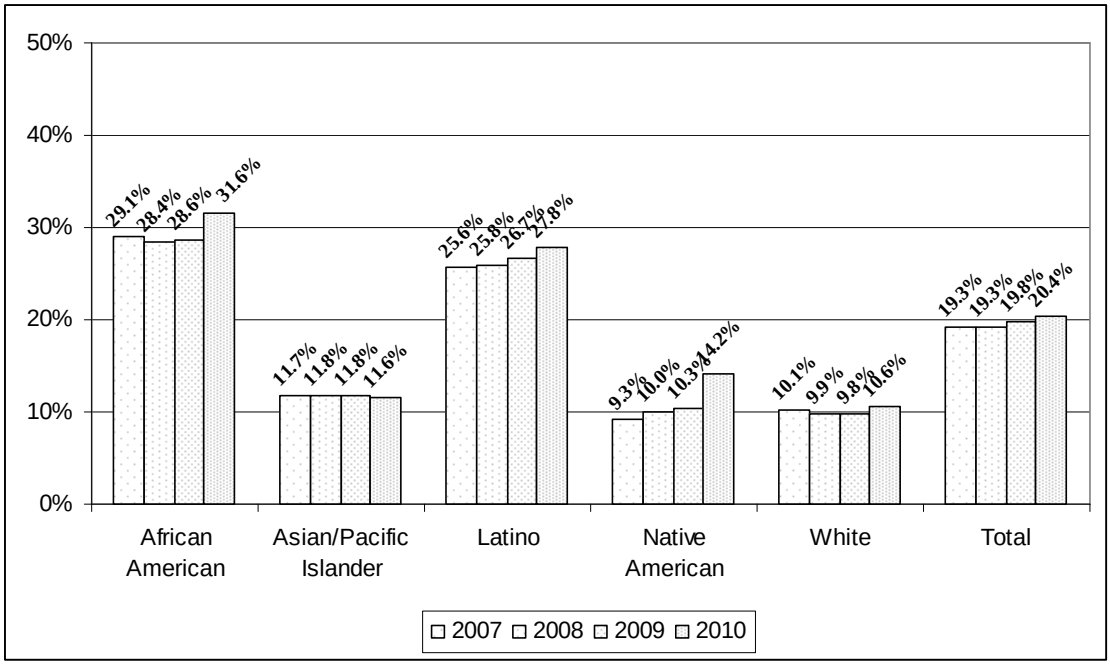
SA 3 at 25.0% has the highest percent of Asian/Pacific Islanders (API) enrolled in Medi-Cal as compared with the lowest in SA 6 at 0.9%.

SA 7 at 86.1% has the highest percent of Latinos enrolled in Medi-Cal as compared with the lowest in SA 5 at 38.9%.

SA 1 at 0.30% has the highest percent of Native Americans enrolled in Medi-Cal as compared with the lowest in SA 6 at 0.06%.

SA 5 at 39.8 % has the highest percent of Whites enrolled in Medi-Cal as compared with the lowest in SA 6 at 1.7%.

FIGURE 8: MEDI-CAL ENROLLMENT RATE[1] BY ETHNICITY
MARCH 2007 - 2010



[1] Medi-Cal Enrollment Rate = Medi-Cal enrolled population divided by total population in each ethnic group.

The African American Medi-Cal enrollment rate has increased by 2.5% from a rate of 29.1% in March 2007 to 31.6% in March 2010.

The Asian/Pacific Islander (API) Medi-Cal enrollment rate decreased by 0.1% from a rate of 11.7% in March 2007 to 11.6% in March 2010.

The Latino Medi-Cal enrollment rate increased 2.2% from 25.6% in March of 2007 to 27.8% in March 2010.

The Native American Medi-Cal enrollment rate increased 4.9% from 9.3% in March of 2007 to 14.2% in March 2010.

The White Medi-Cal enrollment rate increased 0.5% from 10.1% in March of 2007 to 10.6% in March 2010.

TABLE 14: POPULATION ENROLLED IN MEDI-CAL BY AGE GROUP AND SERVICE AREA MARCH 2011

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60+ yrs	SA Total
SA 1	47,800	15,887	20,688	7,491	91,866
Percent	52.0%	**17.3%**	**22.5%**	**8.2%**	4.7%
SA 2	165,782	47,615	69,625	69,972	352,994
Percent	47.0%	13.5%	19.7%	19.8%	18.1%
SA 3	154,690	47,193	57,447	58,273	317,603
Percent	48.7%	14.9%	18.1%	18.3%	16.3%
SA 4	113,691	32,836	43,887	50,404	240,818
Percent	47.2%	13.6%	18.2%	21.0%	12.4%
SA 5	15,383	4,708	8,298	11,620	40,009
Percent	**38.4%**	**12.0%**	20.6%	**29.0%**	2.1%
SA 6*	198,304	57,069	64,415	31,588	351,376
Percent	**56.4%**	16.2%	18.3%	9.1%	18.1%
SA 7	153,753	44,208	46,939	35,785	280,685
Percent	54.8%	15.8%	**16.7%**	12.7%	14.4%
SA 8	140,147	42,459	53,259	33,826	269,691
Percent	52.0%	16.0%	19.6%	12.4%	13.9%
Total	989,550	291,975	364,558	298,959	1,945,042
Percent	50.9%	15.0%	18.7%	15.4%	100.0%

Notes:
1. Bold represents the highest and lowest percent in each group.
2. Data excludes Medi-Cal enrolled who are without Service Area designations (N = 90,660 or 4.05% from the total count of 2,239,690 in the States Meds Beneficiary file.)
3. Data Source: State MEDS File, March 2011.

Differences by Age Group

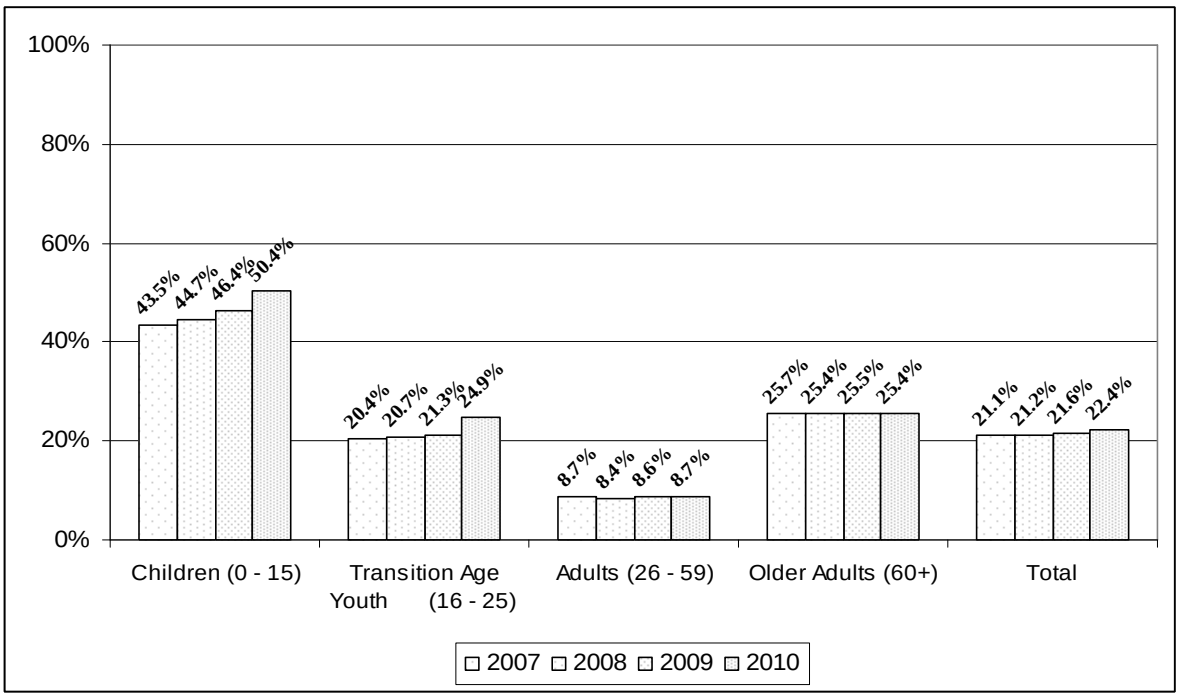
SA 6 at 56.4% has the highest percent of Children enrolled in Medi-Cal as compared with the lowest in SA 5 at 38.4%.

SA 1 at 17.3% has the highest percent of TAY enrolled in Medi-Cal as compared with the lowest in SA 5 at 12.0%.

SA 1 at 22.5% has the highest percent of Adults enrolled in Medi-Cal as compared with the lowest in SA 7 at 16.7%.

SA 5 at 29.0% has the highest percent of Older Adults enrolled in Medi-Cal as compared with the lowest in SA 1 at 8.2%.

FIGURE 9: MEDI-CAL ENROLLMENT RATE[1] BY AGE GROUP MARCH 2007 - 2010



[1] Medi-Cal Enrollment Rate = Medi-Cal enrolled population divided by total population in each age group.

The Child Medi-Cal enrollment rate increased 6.9% from 43.5% in March of 2007 to 50.4% in March 2010.

The TAY Medi-Cal enrollment rate increased 4.5% from 20.4% in March of 2007 to 24.9% in March 2010.

The Adult Medi-Cal enrollment rate is the same at 8.7% in March of 2010 as it was in March of 2007.

The Older Adult Medi-Cal enrollment rate decreased 0.3% from 25.7% in March of 2007 to 25.4% in March 2010.

TABLE 15: POPULATION ENROLLED IN MEDI-CAL BY GENDER AND SERVICE AREA MARCH 2011

Service Area (SA)	Male	Female	SA Total
SA 1	51,295	40,571	91,866
Percent	55.8%	44.2%	4.7%
SA 2	193,996	158,998	352,994
Percent	55.0%	45.0%	18.1%
SA 3	175,181	142,422	317,603
Percent	55.2%	44.8%	16.3%
SA 4	132,463	108,355	240,818
Percent	55.0%	45.0%	12.4%
SA 5	22,381	17,628	40,009
Percent	**55.9%**	**44.1%**	2.1%
SA 6	194,007	157,369	351,376
Percent	55.2%	44.8%	18.1%
SA 7	153,904	126,781	280,685
Percent	**54.8%**	**45.2%**	14.4%
SA 8	149,854	119,837	269,691
Percent	55.6%	44.4%	13.9%
Total	1,073,081	871,961	1,945,042
Percent	55.2%	44.8%	100.0%

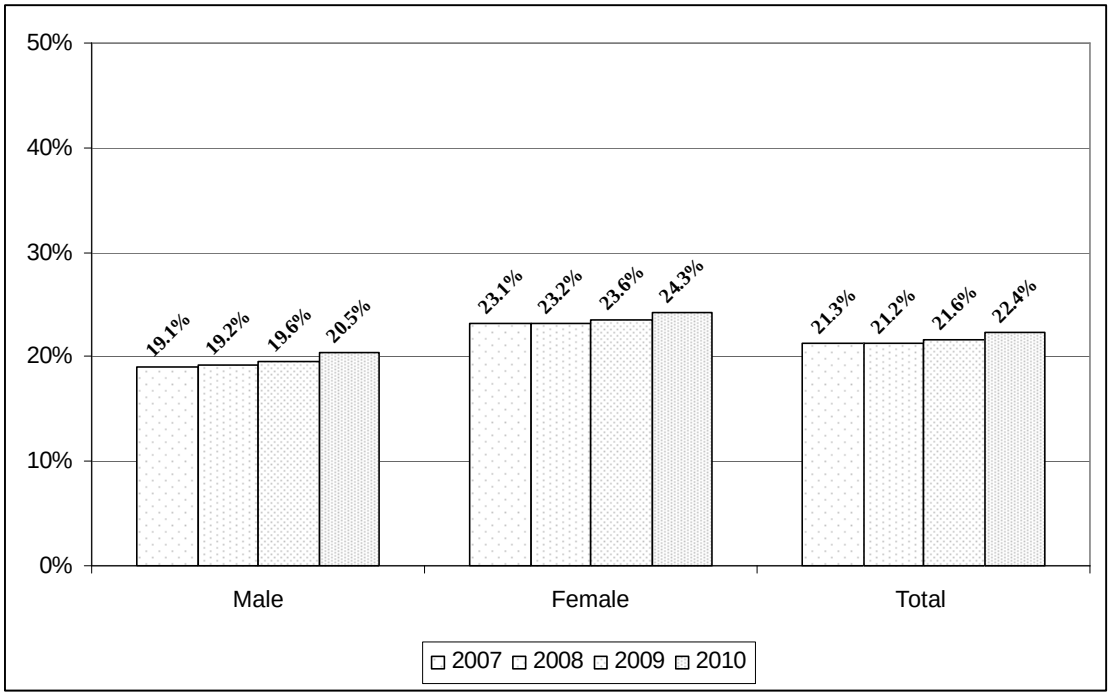
Notes:
1. Bold represents the highest and lowest percent in each group.
2. Data excludes Medi-Cal enrolled who are without Service Area designations (N = 90,660 or 4.05% from the total count of 2,239,690 in the States Meds Beneficiary file.)
3. Data Source: State MEDS File, March 2011.

Differences by Gender

SA 5 at 55.9% has the highest percent of Males enrolled in Medi-Cal as compared with the lowest in SA 7 at 54.8%.

SA 7 at 45.2% has the highest percent of Females enrolled in Medi-Cal as compared with the lowest in SA 5 at 44.1%.

FIGURE 10: MEDI-CAL ENROLLMENT RATE[1] BY GENDER
MARCH 2007 - 2010



[1] Medi-Cal Enrollment Rate = Medi-Cal enrolled population divided by total population in each group.

The Male Medi-Cal enrollment rate increased 1.4% from 19.1% in March of 2007 to 20.5% in March 2010.

The Female Medi-Cal enrollment rate increased 1.2% from 23.1% in March of 2007 to 24.3% in March 2010.

TABLE 16: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG MEDI-CAL ENROLLED POPULATION BY ETHNICITY AND SERVICE AREA MARCH 2011

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Service Area Total
SA 1	1,916	155	3,856	19	1,441	7,386
Percent	25.9%	2.1%	52.2%	**0.30%**	19.5%	4.7%
SA 2	1,115	1,887	16,471	31	8,877	28,381
Percent	3.9%	7.0%	58.0%	0.11%	31.3%	18.1%
SA 3	1,139	6,389	15,624	31	2,352	25,535
Percent	4.5%	**25.0%**	61.2%	0.12%	9.2%	16.3%
SA 4	1,061	2,675	13,447	21	2,158	19,362
Percent	5.5%	13.8%	69.5%	0.11%	11.1%	12.4%
SA 5	438	240	1,251	7	1,281	3,217
Percent	13.6%	7.5%	**38.9%**	0.22%	**39.8%**	2.1%
SA6	8,028	247	19,469	17	490	28,251
Percent	**28.4%**	**0.9%**	68.9%	**0.10%**	**1.7%**	18.1%
SA 7	662	1,062	19,419	29	1,396	22,567
Percent	**2.9%**	4.7%	**86.1%**	0.13%	6.2%	14.4%
SA8	4,635	2,522	12,537	34	1,954	21,683
Percent	21.4%	11.6%	57.8%	0.16%	9.0%	13.9%
Total	18,994	15,177	102,073	188	19,949	156,381
Percent	12.1%	9.7%	65.3%	0.12%	12.8%	100.0%

Note: Bold represents the highest and lowest percent in each group.
[1] SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by California State Department of Mental Health for population living at or below 200% FPL at 8.04%.

Differences by Ethnicity

SA 6 at 28.4% has the highest percent of African-Americans estimated with SED and SMI and enrolled in Medi-Cal as compared with the lowest in SA 7 at 2.9%.

SA 3 at 25.0% has the highest percent of Asian/Pacific Islanders (API) estimated with SED and SMI and enrolled in Medi-Cal as compared with the lowest in SA 6 at 0.9%.

SA 7 at 86.1% has the highest percent of Latinos estimated with SED and SMI and enrolled in Medi-Cal as compared with the lowest in SA 5 at 38.9%.

SA 1 at 0.30% has the highest percent of Native Americans estimated with SED and SMI and enrolled in Medi-Cal as compared with the lowest in SA 6 at 0.10%.

SA 5 at 39.8% has the highest percent of Whites estimated with SED and SMI and enrolled in Medi-Cal as compared with the lowest in SA 6 at 1.7%.

TABLE 17: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG MEDI-CAL ENROLLED POPULATION BY AGE GROUP AND SERVICE AREA MARCH 2011

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60+ yrs	SA Total
SA 1	3,843	1,277	1,663	602	7,386
Percent	52.0%	**17.3%**	**22.5%**	**8.2%**	4.7%
SA 2	13,329	3,828	5,598	5,626	28,381
Percent	47.0%	13.5%	19.7%	19.8%	18.1%
SA 3	12,437	3,794	4,619	4,685	25,535
Percent	48.7%	14.9%	18.1%	18.3%	16.3%
SA 4	9,141	2,640	3,529	4,052	19,362
Percent	47.2%	13.6%	18.2%	21.0%	12.4%
SA 5	1,237	379	667	934	3,217
Percent	**38.5%**	**11.8%**	20.7%	**29.0%**	2.1%
SA 6	15,944	4,588	5,179	2,540	28,251
Percent	**56.4%**	16.2%	18.3%	9.0%	18.1%
SA 7	12,362	3,554	3,774	2,877	22,567
Percent	54.8%	15.7%	**16.7%**	12.7%	14.4%
SA 8	11,268	3,414	4,282	2,720	21,683
Percent	52.0%	15.7%	19.7%	12.5%	13.9%
Total	79,560	23,475	29,310	24,036	156,381
Percent	50.9%	15.0%	18.7%	15.4%	100.0%

Note: Bold represents the highest and lowest percent in each group.
[1] SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by California State Department of Mental Health for population living at or below 200% FPL at 8.04%.

Differences by Age Group

SA 6 at 56.4% has the highest percent of Children estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest in SA 5 at 38.5%.

SA 1 at 17.3% has the highest percent of TAY estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest in SA 5 at 11.8%.

SA 1 at 22.5% has the highest percent of Adults estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest in SA 7 at 16.7%.

SA 5 at 29.0% has the highest percent of Older Adults estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest in SA 1 at 8.2%.

TABLE 18: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG MEDI-CAL ENROLLED POPULATION BY GENDER AND SERVICE AREA MARCH 2011

Service Area (SA)	Male	Female	SA Total
SA 1	4,124	3,262	7,386
Percent	55.8%	44.2%	4.7%
SA 2	15,597	12,783	28,381
Percent	55.0%	45.0%	18.1%
SA 3	14,085	11,451	25,535
Percent	55.2%	44.8%	16.3%
SA 4	10,650	8,712	19,362
Percent	55.0%	45.0%	12.4%
SA 5	1,799	1,417	3,217
Percent	**56.0%**	**44.0%**	2.1%
SA 6	15,598	12,652	28,251
Percent	55.2%	44.8%	18.1%
SA 7	12,374	10,193	22,567
Percent	**54.8%**	**45.2%**	14.4%
SA 8	12,048	9,635	21,683
Percent	55.6%	44.4%	13.9%
Total	86,276	70,106	156,381
Percent	55.2%	44.8%	100.0%

Note: Bold represents the highest and lowest percent in each group.

[1] SED=Serious Emotional Disturbance (children), SMI=Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by California State Department of Mental Health for population living at or below 200% FPL at 8.04%.

Differences by Gender

SA 5 at 56.0% has the highest percent of Males estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest percent in SA 7 at 54.8%.

SA 7 at 45.2% has the highest percent of Females estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest percent in SA 5 at 44.0%.

TABLE 19: POPULATION ENROLLED IN MEDI-CAL BY THRESHOLD LANGUAGE AND SERVICE AREA
MARCH 2011

Service Area (SA)	Armen-ian	Cambod-ian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnam-ese	Total
SA 1	81	11	14	**66,573**	27	65	5	19	5	**24,756**	145	72	91,866
Percent	0.1%	0.0%	0.0%	**72.5%**	0.0%	0.1%	0.0%	0.0%	0.0%	**26.9%**	0.2%	0.1%	100.0%
SA 2	**48,838**	165	160	**144,193**	**6,301**	2,999	262	210	**3,847**	**138,960**	2,890	2,259	352,994
Percent	**13.8%**	0.0%	0.0%	**40.8%**	**1.8%**	0.8%	0.1%	0.1%	**1.1%**	**39.4%**	0.8%	0.6%	100.0%
SA 3	2,022	1,006	**19,796**	**149,690**	215	1,694	**14,834**	**6,349**	96	**103,655**	1,913	**15,766**	317,603
Percent	0.6%	0.3%	**6.2%**	**47.1%**	0.1%	0.5%	**4.7%**	**2.0%**	0.0%	**32.6%**	0.6%	**5.0%**	100.0%
SA 4	**7,235**	527	**6,003**	**83,900**	464	**10,683**	836	826	**4,807**	**121,034**	2,990	1,395	240,818
Percent	**3.0%**	0.2%	**2.5%**	**34.8%**	0.2%	**4.4%**	0.3%	0.3%	**2.0%**	**50.3%**	1.2%	0.6%	100.0%
SA 5	47	7	43	**24,130**	**3,382**	256	121	90	1,313	**10,318**	55	54	40,009
Percent	0.1%	0.0%	0.1%	**60.3%**	**8.5%**	0.6%	0.3%	0.2%	3.3%	**25.8%**	0.1%	0.1%	100.0%
SA 6	22	125	56	**173,817**	6	833	22	17	22	**176,287**	82	65	351,376
Percent	0.0%	0.0%	0.0%	**49.5%**	0.0%	0.2%	0.0%	0.0%	0.0%	**50.2%**	0.0%	0.0%	100.0%
SA 7	650	727	482	**131,376**	28	1,827	866	382	56	**142,450**	945	610	280,685
Percent	0.2%	0.3%	0.2%	**46.8%**	0.0%	0.7%	0.3%	0.1%	0.0%	**50.8%**	0.3%	0.2%	100.0%
SA 8	91	**5,290**	191	**156,611**	286	2,160	376	275	135	**100,045**	1,680	2,393	269,691
Percent	0.0%	**2.0%**	0.1%	**58.1%**	0.1%	0.8%	0.1%	0.1%	0.1%	**37.1%**	0.6%	0.9%	100.0%
Total	**58,986**	**7,858**	**26,745**	**930,290**	**10,709**	**20,517**	**17,322**	**8,168**	**10,281**	**817,505**	**10,700**	**22,614**	**1,941,695**
Percent	**3.0%**	**0.4%**	**1.4%**	**47.8%**	**0.6%**	**1.1%**	**0.9%**	**0.4%**	**0.5%**	**42.0%**	**0.6%**	**1.2%**	**100.0%**

Note: SA Threshold Languages are in bold. Arabic is a Countywide threshold language, N = 3,347 (0.2%). 4,149 (0.2%) individuals enrolled in Medi-Cal reported "Other" as a primary language. 78,084 (3.5%) were "Unknown/Missing" for primary language and 90,660 (4.1%) were missing a Service Area designation.

Consumers Served In Short Doyle/Medi-Cal Facilities

TABLE 20: CONSUMERS SERVED IN SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY AND SERVICE AREA FY 2010 – 2011

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	SA Total
SA 1	4,232	127	4,666	65	2,769	11,859
Percent	36.0%	1.0%	39.3%	0.54%	23.2%	5.4%
SA 2	4,119	1,042	15,125	131	10,600	31,017
Percent	13.3%	3.4%	48.8%	0.42%	34.1%	14.1%
SA 3	3,402	1,948	14,440	117	4,429	24,336
Percent	14.0%	**8.0%**	59.3%	0.50%	18.2%	11.0%
SA 4	13,844	2,881	25,434	285	10,028	52,472
Percent	26.4%	5.5%	48.5%	0.54%	19.1%	23.8%
SA 5	3,954	345	3,305	48	4,824	12,476
Percent	31.7%	2.8%	**26.5%**	0.38%	**38.7%**	5.7%
SA 6	15,807	269	12,275	57	1,661	30,069
Percent	**52.6%**	**0.9%**	40.8%	**0.20%**	**5.5%**	13.6%
SA 7	3,021	538	16,697	262	2,937	23,455
Percent	**12.9%**	2.3%	**71.2%**	**1.12%**	12.5%	10.6%
SA8	10,893	2,413	13,758	135	7,526	34,725
Percent	31.4%	6.9%	39.6%	0.40%	21.7%	15.8%
Total	47,859	8,591	90,127	924	38,607	186,108
Percent	25.7%	4.6%	48.4%	0.5%	20.8%	100.0%

Notes: Bold represents the highest and lowest percent in each group. Excludes those that report "Other" as their ethnic group, N = 3,367; and those whose ethnicity is unknown N = 5,026. Total reflects unduplicated count of consumers served. Some consumers (N = 38,066) were served in more than one SA or 224,174 duplicated count. Data Source: LACDMH - IS Database, October 2011.

Differences by Ethnicity

SA 6 at 52.6% has the highest percent of African-American consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percent in SA 7 at 12.9%.

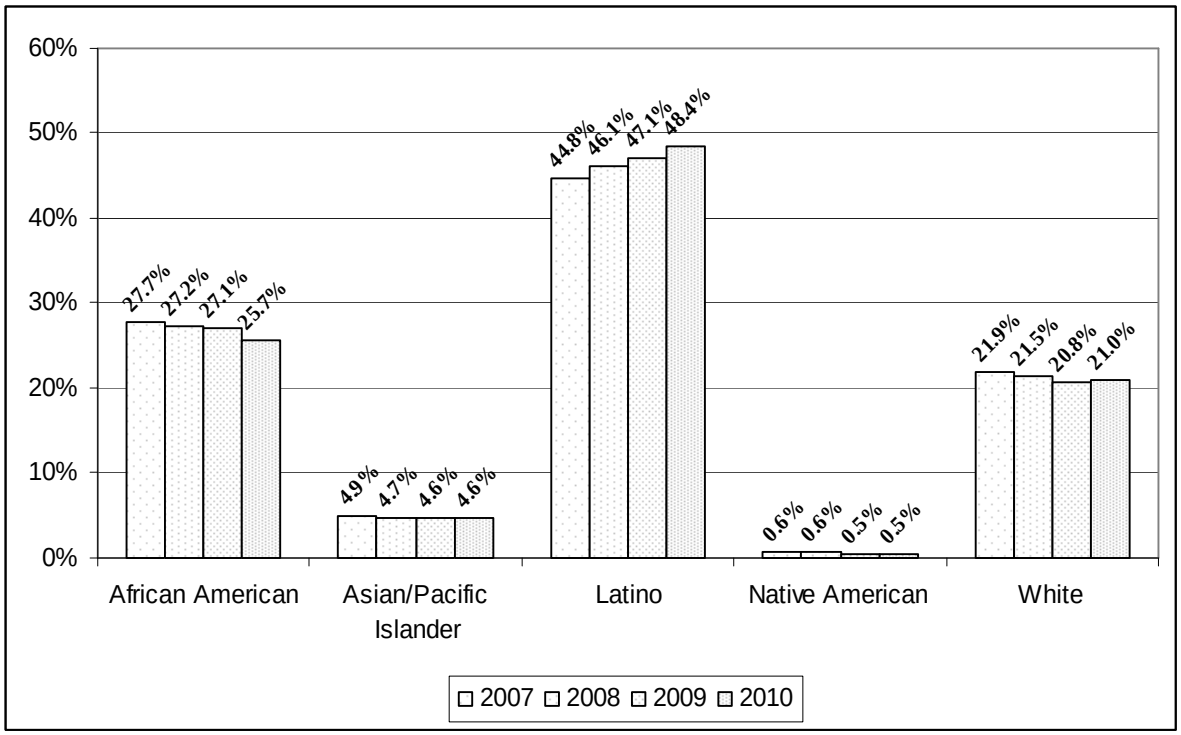
SA 3 at 8.0% has the highest percent of Asian/Pacific Islander (API) consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percent in SA 6 at 0.9%.

SA 7 at 71.2% has the highest percent of Latino consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percent in SA 5 at 26.5%.

SA 7 at 1.12% has the highest percent of Native American consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percent in SA 6 at 0.20%.

SA 5 at 38.7% has the highest percent of White consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percent in SA 6 at 5.5%.

FIGURE 11: CONSUMERS SERVED IN SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY FY 07-08 TO FY 10-11



The percent of African Americans served in Short Doyle/Medi-Cal facilities decreased by 2.0% from 27.7% to 25.7% between FY 07-08 and FY 10-11.

The percent of Asian/Pacific Islanders (API) served in Short Doyle/Medi-Cal facilities decreased by 0.3% from 4.9% to 4.6% between FY 07-08 and FY 10-11.

The percent of Latinos served in Short Doyle/Medi-Cal facilities increased by 3.6% from 44.8% to 48.4% between FY 07-08 and FY 10-11.

The percent of Native Americans served in Short Doyle/Medi-Cal facilities decreased by 0.1% from 0.6% to 0.5% between FY 07-08 and FY 10-11.

The percent of Whites served in Short Doyle/Medi-Cal facilities decreased by 0.9% from 21.9% to 21.0% between FY 07-08 and FY 10-11.

TABLE 21: CONSUMERS SERVED IN SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP AND SERVICE AREA FY 2010 - 2011

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60+ yrs	SA Total
SA 1	4,423	4,137	3,161	318	12,039
Percent	36.7%	**34.4%**	**26.3%**	**2.6%**	5.4%
SA 2	9,554	7,598	12,747	2,023	31,922
Percent	30.0%	23.8%	39.9%	6.3%	14.2%
SA 3	10,691	5,182	7,718	1,236	24,827
Percent	**43.1%**	20.9%	31.1%	4.9%	11.1%
SA 4	13,495	11,306	24,919	3,601	53,321
Percent	25.3%	21.2%	46.7%	6.8%	23.8%
SA 5	2,953	2,099	6,842	925	12,819
Percent	**23.0%**	16.4%	**53.4%**	**7.2%**	5.7%
SA 6	11,040	4,719	13,113	1,379	30,251
Percent	36.5%	**15.6%**	43.3%	4.6%	13.5%
SA 7	9,778	6,334	6,699	904	23,715
Percent	41.2%	26.7%	28.1%	4.0%	10.6%
SA 8	11,330	6,020	15,783	2,147	35,280
Percent	32.1%	17.1%	44.7%	6.1%	15.7%
Total	61,788	36,267	79,659	11,761	189,475
Percent	32.6%	19.1%	42.0%	6.3%	100.0%

Notes:
Bold represents the highest and lowest percent in each group.
Total reflects unduplicated count of consumers served. Some consumers (N = 38,066) were served in more than one Service Area. Excludes consumers not reporting their date of birth, N = 252. Data Source: LACDMH - IS Database, October 2011.

Differences by Age Group

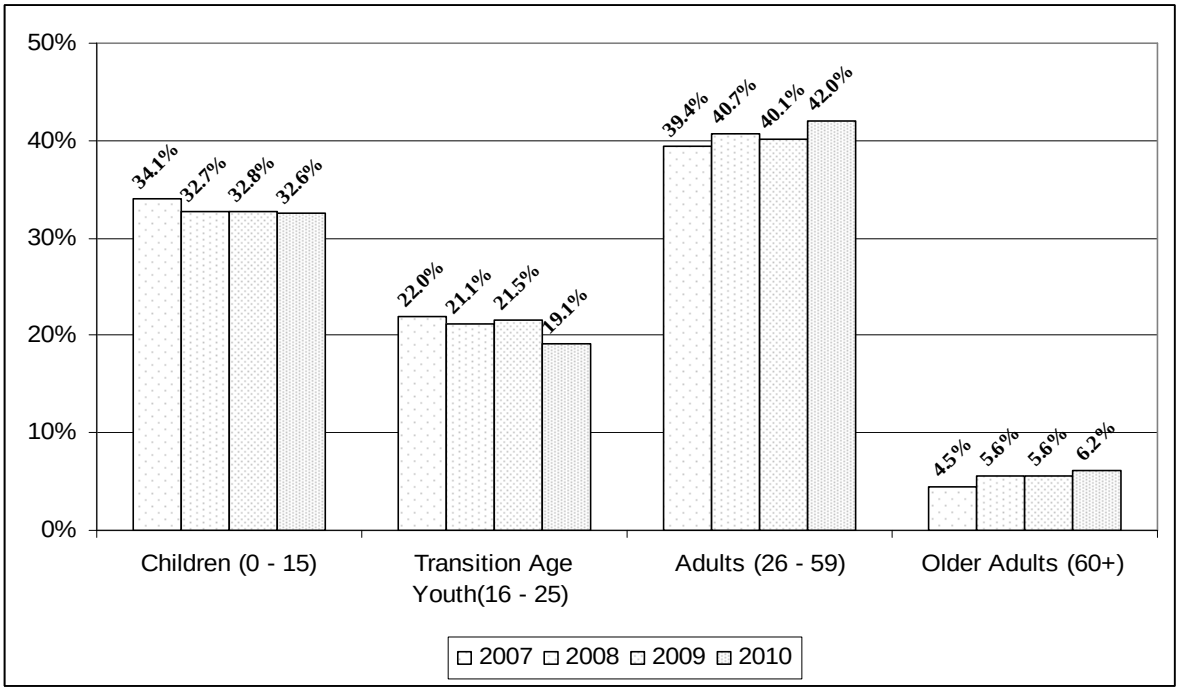
SA 3 at 43.1% has the highest percent of Children served as compared with the lowest percent in SA 5 at 23.0%.

SA 1 at 34.4% has the highest percent of TAY served as compared with the lowest percent in SA 6 at 15.6%.

SA 5 at 53.4% has the highest percent of Adults served as compared with the lowest percent in SA 1 at 26.3%.

SA 5 at 7.2% has the highest percent of Older Adults served as compared with the lowest percent in SA 1 at 2.6%.

FIGURE 12: CONSUMERS SERVED IN SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP FY 07-08 TO FY 10-11



The percent of Children served in Short Doyle/Medi-Cal facilities decreased by 1.5% from 34.1% to 32.6% between FY 07-08 and FY 10-11.

The percent of TAY served in Short Doyle/Medi-Cal facilities decreased by 2.9% from 22.0% to 19.1% between FY 07-08 and FY 10-11.

The percent of Adults served in Short Doyle/Medi-Cal facilities increased by 2.6% from 39.4% to 42.0% between FY 07-08 and FY 10-11.

The percent of Older Adults served in Short Doyle/Medi-Cal facilities increased by 1.7% from 4.5% to 6.2% between FY 07-08 and FY 10-11.

TABLE 22: CONSUMERS SERVED IN SHORT DOYLE/MEDI-CAL FACILITIES BY GENDER AND SERVICE AREA FY 2010 – 2011

Service Area (SA)	Male	Female	SA Total
SA 1	6,810	5,229	12,039
Percent	56.6%	43.4%	5.4%
SA 2	17,257	14,665	31,922
Percent	54.1%	45.9%	14.2%
SA 3	12,779	12,048	24,827
Percent	51.5%	48.5%	11.1%
SA 4	31,243	22,078	53,321
Percent	**58.6%**	**41.4%**	23.8%
SA 5	6,807	6,012	12,819
Percent	53.1%	46.9%	5.7%
SA 6	14,443	15,808	30,251
Percent	**47.7%**	**52.3%**	13.5%
SA 7	12,897	10,818	23,715
Percent	54.4%	45.6%	10.6%
SA 8	17,702	17,578	35,280
Percent	50.2%	49.8%	15.7%
Total	99,385	90,090	189,475
Percent	52.5%	47.5%	100.0%

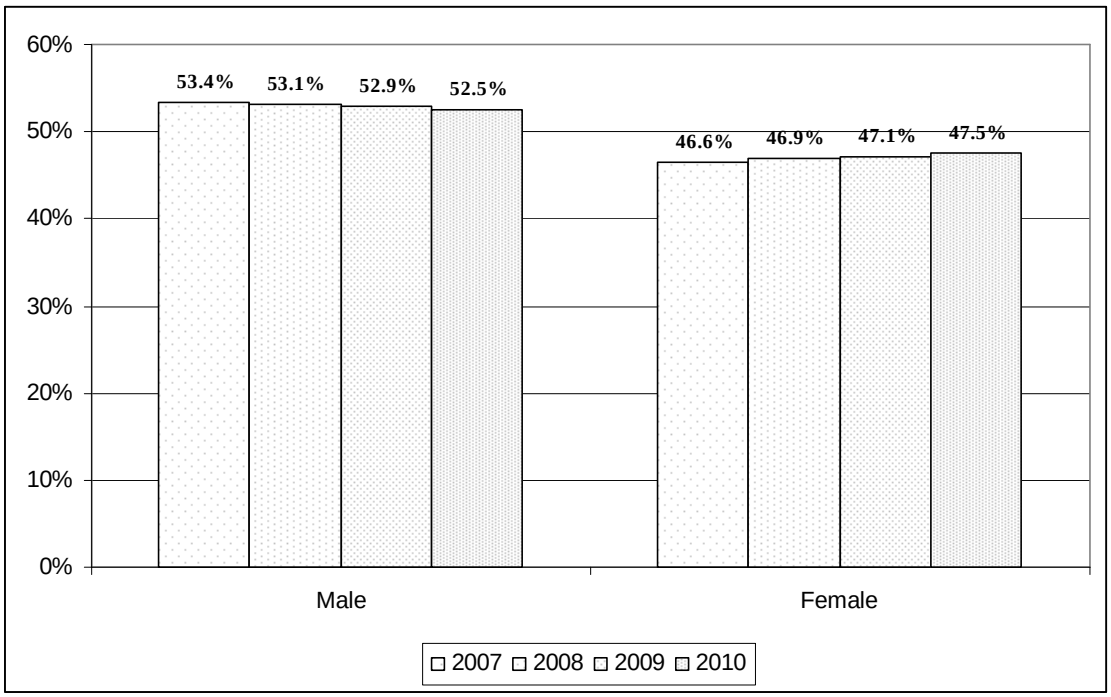
Notes:
Bold represents the highest and lowest percent in each group. Excludes consumers not reporting their gender, N = 46.
Total reflects unduplicated count of consumers served. Some consumers (N = 38,066) were served in more than one Service Area or 224,174 duplicated count. Data Source: LACDMH - IS Database, October 2011.

Differences by Gender

SA 4 at 58.6% has the highest percent of Males served in Short Doyle/Medi-Cal facilities as compared with the lowest percent in SA 6 at 47.7%.

SA 6 at 52.3% has the highest percent of Females served in Short Doyle/Medi-Cal facilities as compared with the lowest percent in SA 1 at 41.4%.

FIGURE 13: CONSUMERS SERVED IN SHORT DOYLE/MEDI-CAL FACILITIES BY GENDER FY 07-08 TO FY 10-11



The percent of Males served in Short Doyle/Medi-Cal facilities decreased by 0.9% from 53.4% to 52.5% between FY 07-08 and FY 10-11.

The percent of Females served in Short Doyle/Medi-Cal facilities decreased by 0.9% from 46.6% to 47.5% between FY 07-08 and FY 10-11.

TABLE 23: CONSUMERS SERVED IN SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP AND THRESHOLD LANGUAGE FY 2010 - 2011

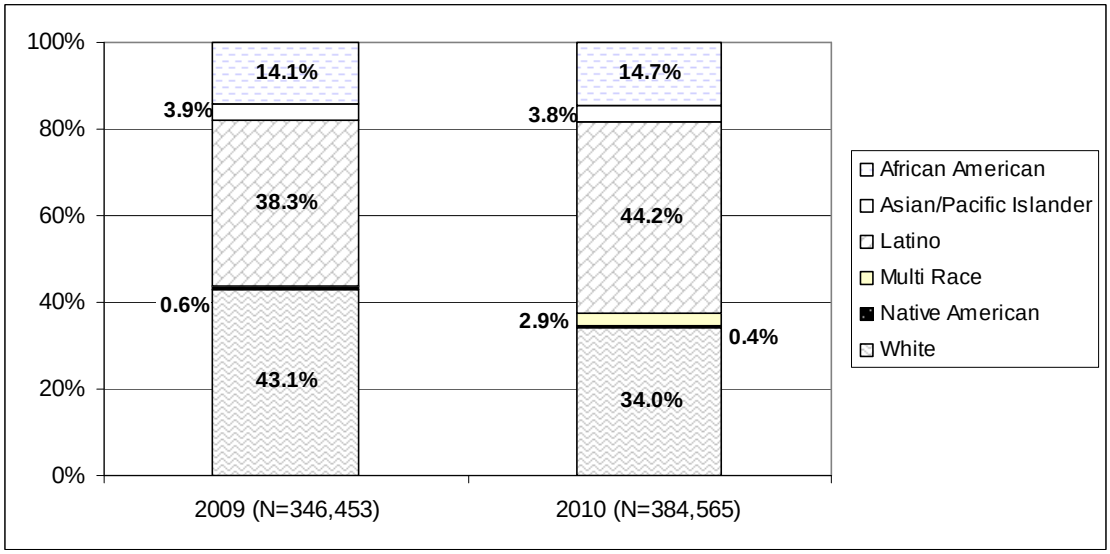
Age Group	Arabic	Armen-ian	Cambod-ian	Canton-ese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnam-ese	Total
Children	25	116	43	74	43,468	34	93	78	18	12	17,213	23	62	61,259
Percent	0.04%	0.19%	0.07%	0.12%	70.96%	0.06%	0.15%	0.13%	0.03%	0.02%	28.10%	0.04%	0.10%	100.00%
TAY[1]	8	95	54	32	28,417	34	56	50	23	16	6,673	43	43	35,536
Percent	0.02%	0.27%	0.15%	0.09%	79.97%	0.10%	0.16%	0.14%	0.06%	0.05%	18.78%	0.12%	0.12%	100.00%
Adults	87	818	683	285	60,296	253	601	234	139	131	11,307	281	467	75,582
Percent	0.12%	1.08%	0.90%	0.38%	79.78%	0.33%	0.80%	0.31%	0.18%	0.17%	14.96%	0.37%	0.62%	100.00%
Older Adults	19	262	203	124	7,281	98	218	120	36	97	2,390	76	262	11,186
Percent	0.17%	2.34%	1.81%	1.11%	65.09%	0.88%	1.95%	1.07%	0.32%	0.87%	21.37%	0.68%	2.34%	100.00%
Total	139	1,291	983	515	140,092	419	968	482	216	256	37,583	423	834	184,201
Percent	0.08%	0.70%	0.53%	0.28%	76.05%	0.23%	0.53%	0.26%	0.12%	0.14%	20.40%	0.23%	0.45%	100.00%

[1] Transition Age Youth. 5,274 (2.9%) consumers served in SD/MC facilities reported "Other" as their primary language. 830 (0.4%) consumers served in SD/MC facilities reported their primary language as "Unknown."

Summary Demographic Needs Assessment by Service Area

Service Area 1

FIGURE 14: TOTAL POPULATION BY ETHNICITY
CY 2009-2010 - SA 1



Note: Data for Multi Race is not available for 2009 population estimates.

FIGURE 15: TOTAL POPULATION BY AGE GROUP
CY 2009-2010 - SA 1

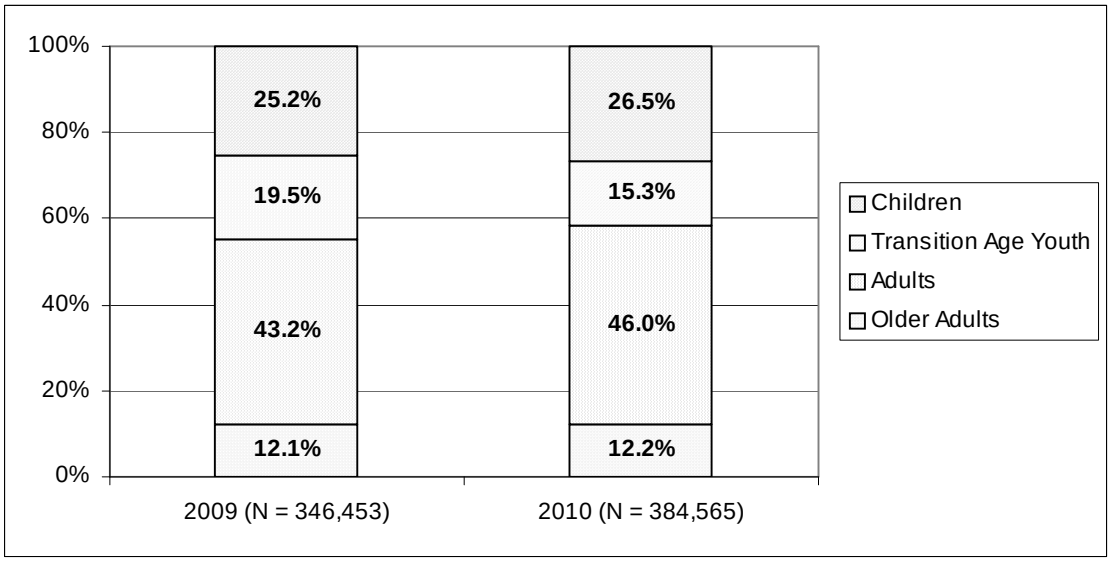
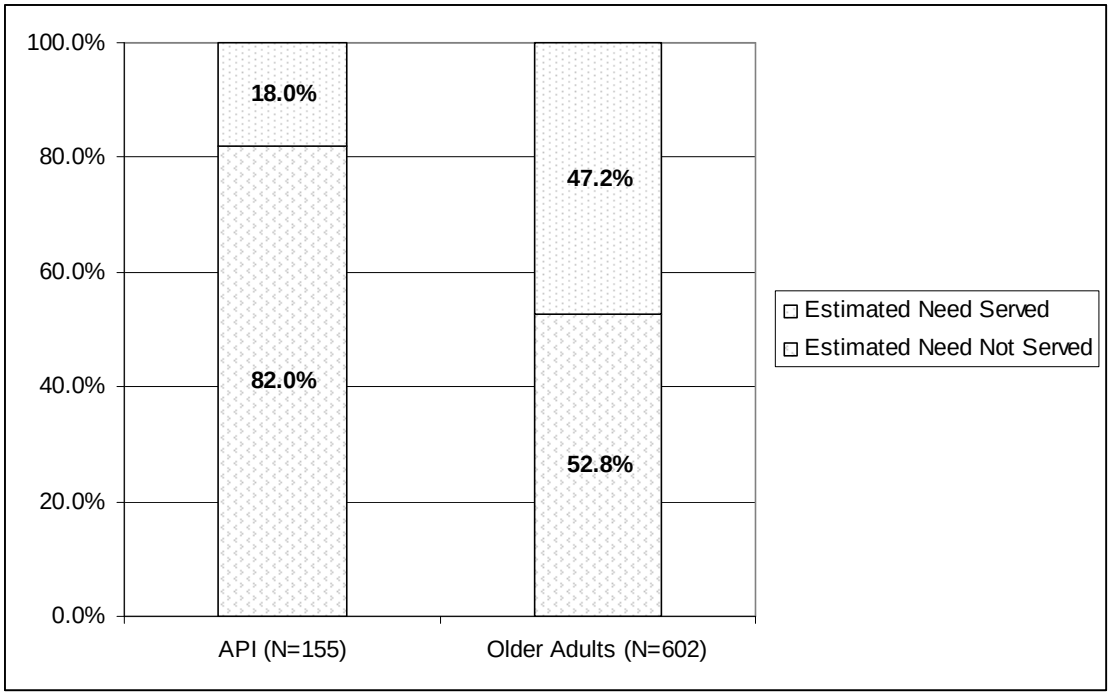


FIGURE 16: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
PENETRATION RATE BY ETHNICITY AND AGE GROUP
FY 2010-2011 - SA 1

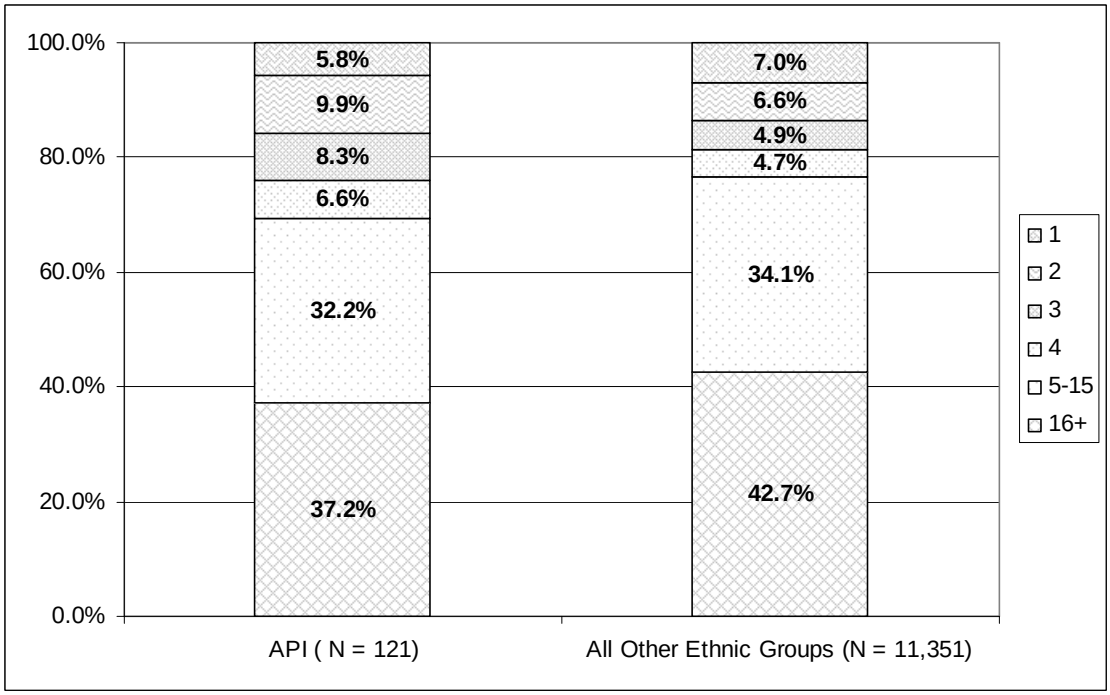


API = Asian/Pacific Islander

Among all ethnic groups reported, the Asian / Pacific Islander (API) population has an estimated unmet need for services in SA 1. The Penetration Rate is calculated as the proportion of Medi-Cal consumers served out of the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct a needs assessment indicates that API consumers served in SA 1 represent 82.0%, while 18.0% are estimated to remain in need of services.

Among all age groups reported, Older Adults have an estimated unmet need for services in SA 1. Using Penetration Rate to conduct a needs assessment indicates that Older Adults served in SA 1 represent 52.8%, while 47.2% are estimated to remain in need of services.

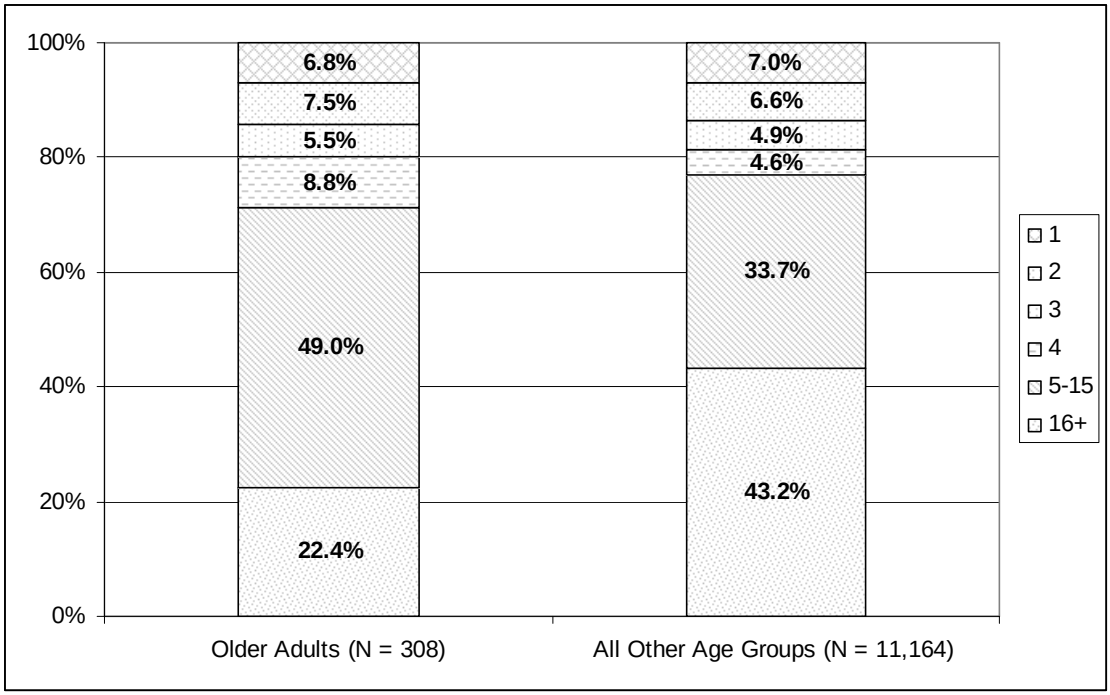
FIGURE 17: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
RETENTION RATE BY ETHNICITY
FY 2010-2011 - SA 1



Retention Rate = Number of Outpatient Claims

Among Asian/Pacific Islanders (API) that received Outpatient services in SA 1, 30.6% (5.8 + 9.9 + 8.3 + 6.6 = 30.6%) received four or fewer services compared to 23.2% (7.0 + 6.6 + 4.9 + 4.7 = 23.2%) for all other ethnic groups; 32.2% received 5 to 15 services compared to 34.1% for all other ethnic groups; and 37.2% received 16 or more services compared to 42.7% for all other ethnic group consumers that received Outpatient Services in SA 1.

FIGURE 18: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
RETENTION RATE BY AGE GROUP
FY 2010-2011 - SA 1

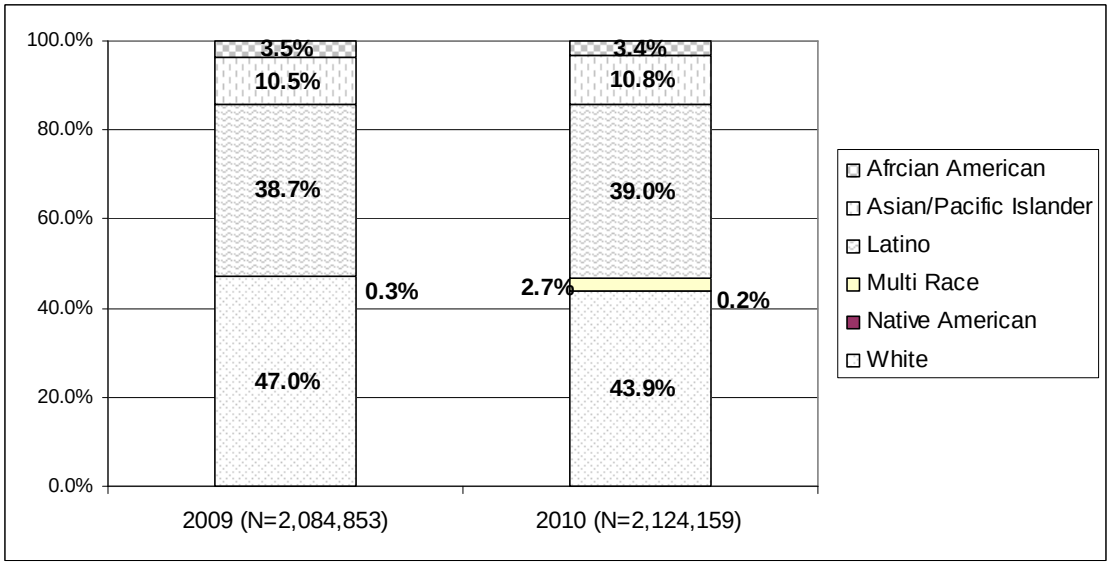


Retention Rate = Number of Outpatient Claims

Among the Older Adults that received Outpatient services in SA 1, 28.6% (6.8 + 7.5 + 5.5 + 8.8 = 28.6%) received four or fewer services compared to 23.1% (7.0 + 6.6 + 4.9 + 4.6 = 23.1%) for all other age groups; 49.0% received 5 to 15 services compared to 33.7% for all other age groups; and 22.4% received 16 or more services compared to 43.2% for all other age group consumers that received Outpatient services in SA 1.

Service Area 2

FIGURE 19: TOTAL POPULATION BY ETHNICITY
CY 2009-2010 - SA 2



Note: Data for Multi Race is not available for 2009 population estimates.

FIGURE 20: TOTAL POPULATION BY AGE GROUP
CY 2009-2010 - SA 2

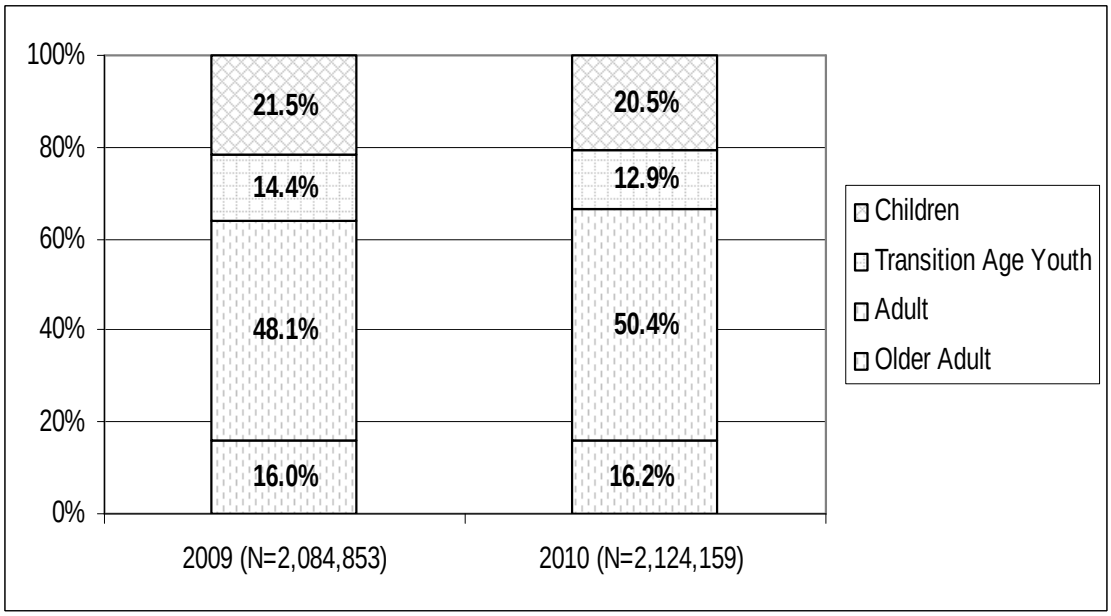
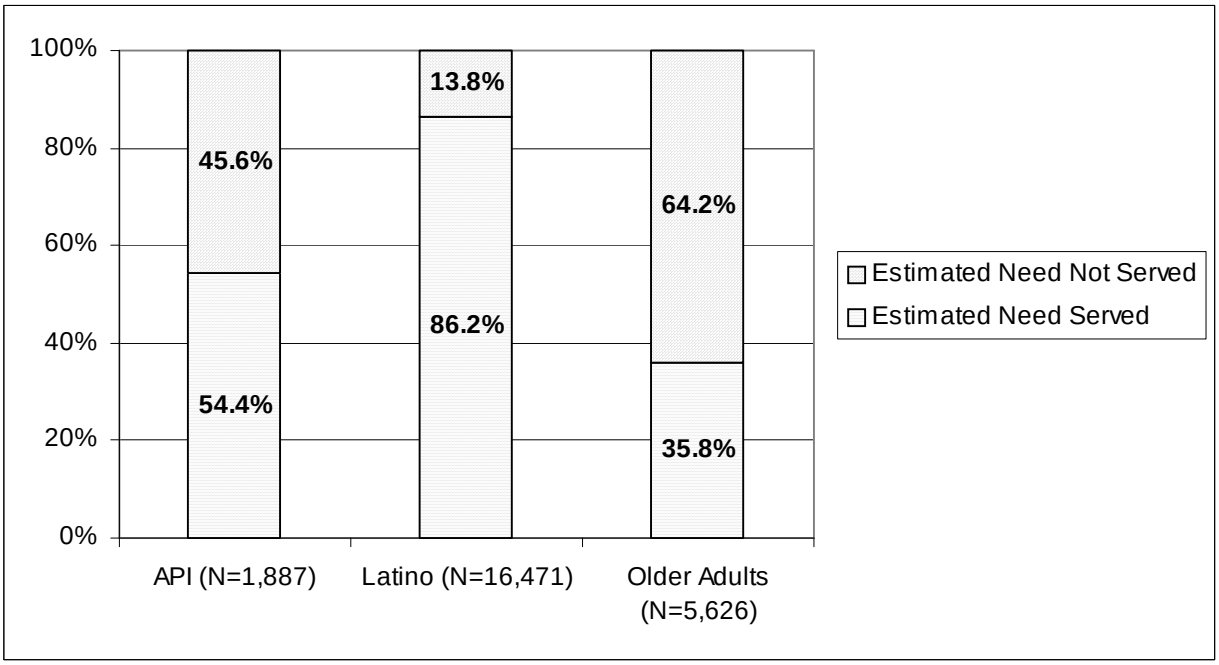


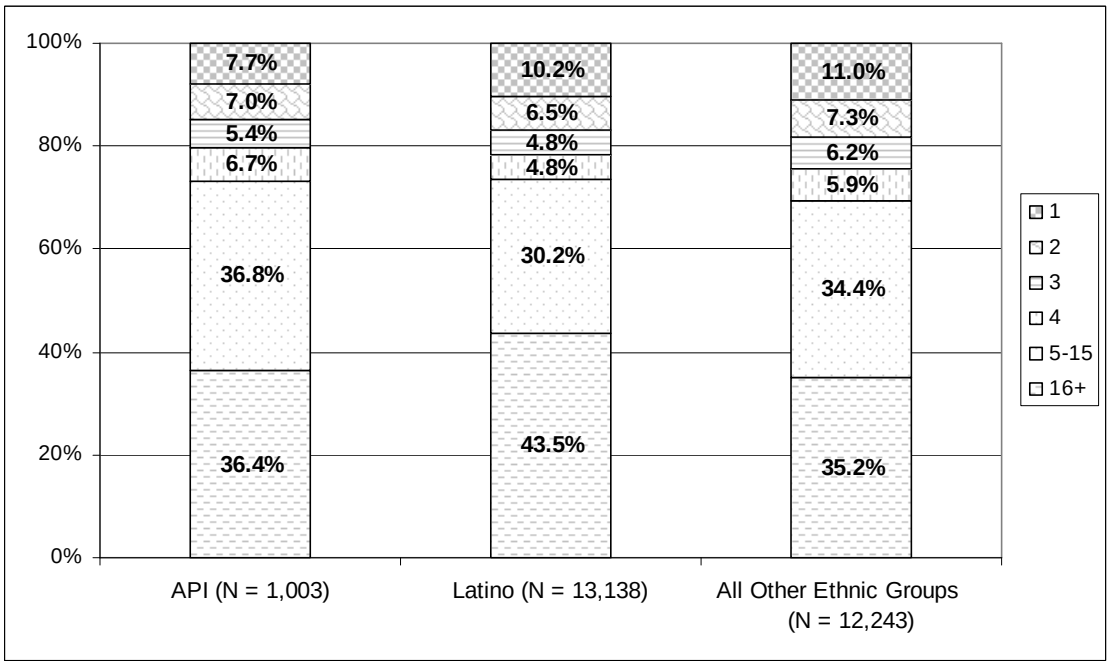
FIGURE 21: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
PENETRATION RATE BY ETHNICITY AND AGE GROUP
FY 2010-2011 - SA 2



API = Asian/Pacific Islander

Among all ethnic and age groups reported, the Asian/Pacific Islander (API) population, the Latino population, and the Older Adult population have estimated unmet need for services in SA 2. The Penetration Rate is calculated as the proportion of Medi-Cal consumers served out of the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct a needs assessment indicates that API consumers served in SA 2 represent 54.4%, while 45.6% are estimated to remain in need of services; Latino consumers served in SA 2 represent 86.2%, while 13.8% are estimated to remain in need of services; and Older Adult consumers served in SA 2 represent 35.8%, while 64.2% are estimated to remain in need of services.

FIGURE 22: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
RETENTION RATE BY ETHNICITY
FY 2010-2011 - SA 2

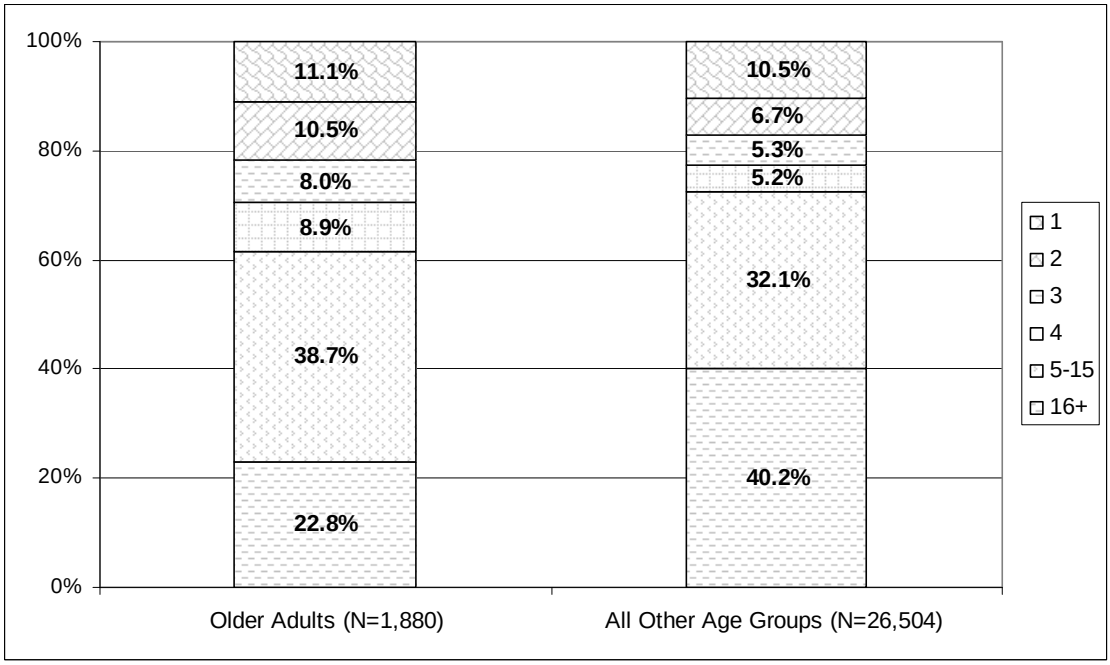


API=Asian/Pacific Islander, Retention Rate = Number of Outpatient Claims

Among the Asian/Pacific Islanders (API) that received Outpatient services 26.8% (7.7 + 7.0 + 5.4 + 6.7 = 26.8%) received four or fewer services as compared to 26.3% (10.2 + 6.5 + 4.8 + 4.8 = 26.3%) for Latinos, and 30.4% (11.0 + 7.3 + 6.2 + 5.9 = 30.4%) for all other ethnic groups.

Among the Asian/Pacific Islanders (API) that received Outpatient services 36.8% received 5 to 15 services, and 36.4% received 16 or more services; as compared to Latinos of which 30.2% received 5 to 15 services, and 43.5% received 16 or more services; and all other ethnic groups of which 34.4% received 5 to 15 services, and 35.2% received 16 or more services.

FIGURE 23: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT: RETENTION RATE BY AGE GROUP FY 2010-2011 - SA 2

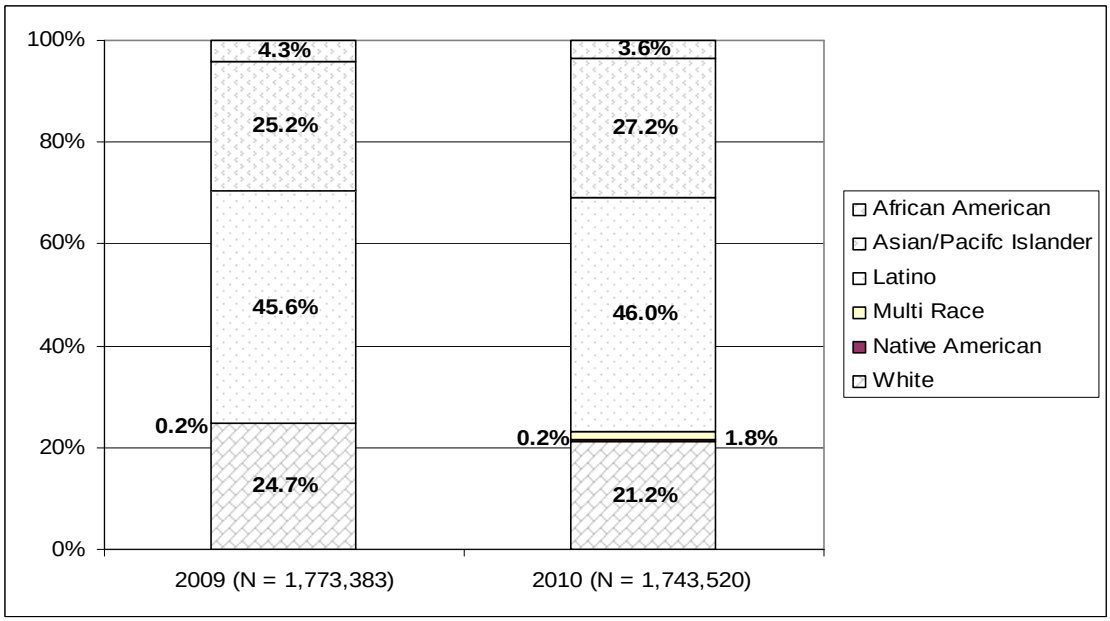


Retention Rate = Number of Outpatient Claims

Among the Older Adults that received Outpatient services, 38.5% (11.1 + 10.5 + 8.0 + 8.9 = 38.5%) received four or fewer services compared to 27.7% (10.5 + 6.7 + 5.3 + 5.2 = 27.7%) for all other age groups; 38.7% received 5 to 15 services compared to 32.1% for all other age groups; 22.8% received 16 or more services compared to 40.2% for all other age groups that received Outpatient services in SA 2.

Service Area 3

FIGURE 24: TOTAL POPULATION BY ETHNICITY
CY 2009-2010 - SA 3



Note: Data for Multi Race is not available for 2009 population estimates.

FIGURE 25: TOTAL POPULATION BY AGE GROUP
CY 2009-2010 - SA 3

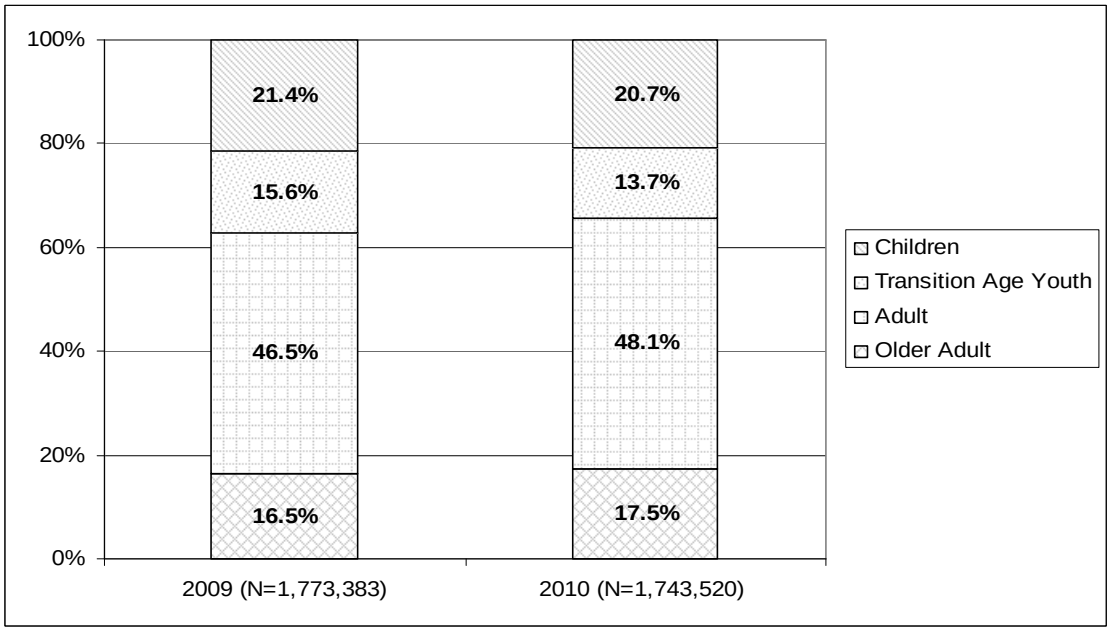
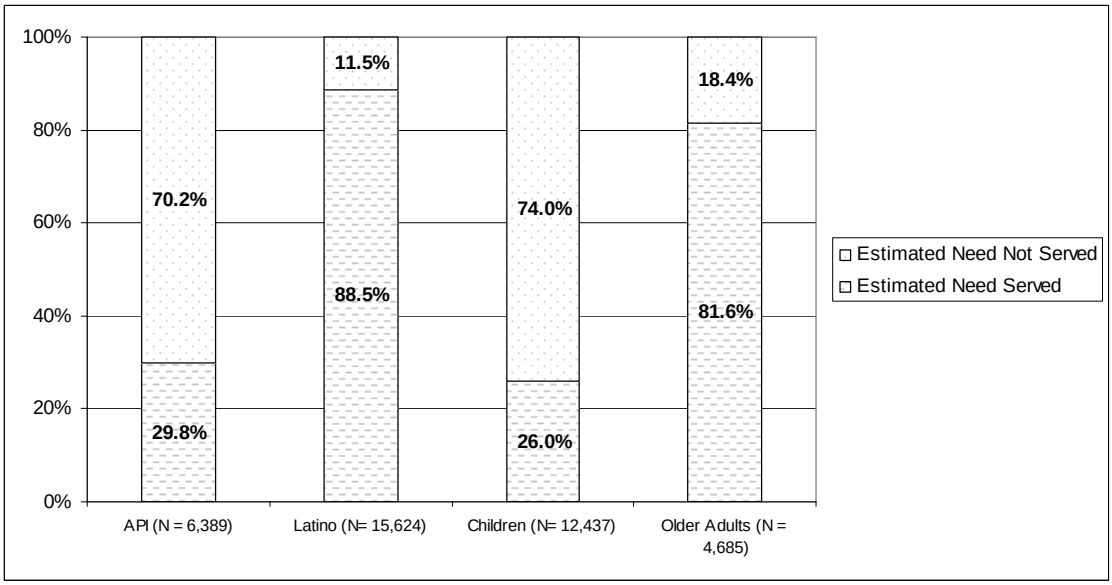


FIGURE 26: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT: PENETRATION RATE BY ETHNICITY AND AGE GROUP FY 2010-2011 - SA 3

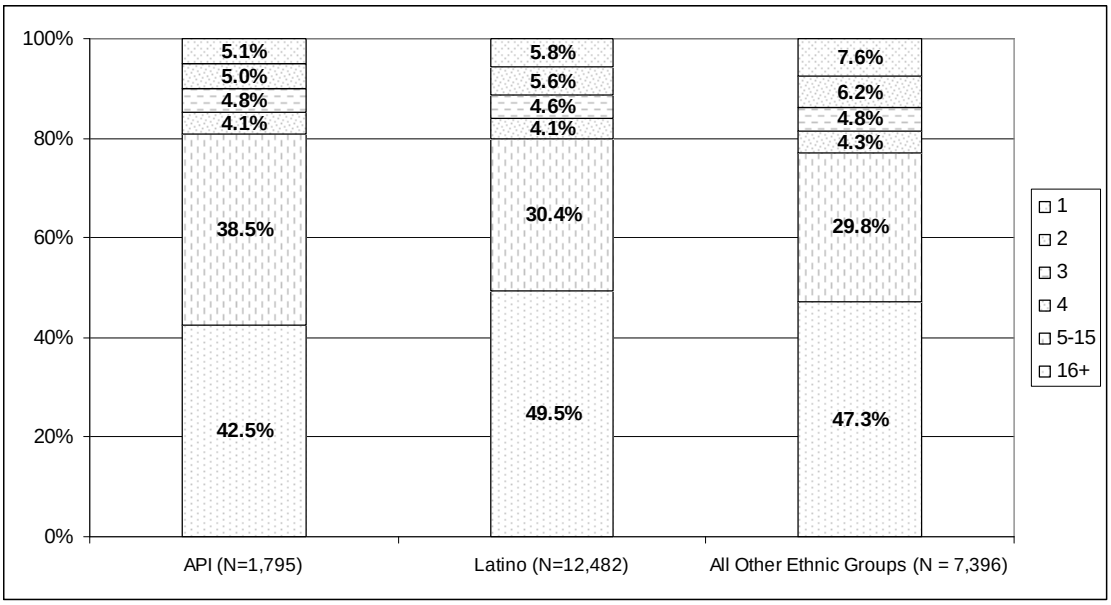


API=Asian/Pacific Islander

Among all ethnic groups reported, the Asian / Pacific Islander (API) and the Latino populations have an estimated unmet need for services in SA 3. The Penetration Rate is calculated as the proportion of Medi-Cal consumers served out of the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct needs assessment indicates that API consumers served in SA 3 represent 29.8%, while 70.2% are estimated to remain in need of services; Latino consumers served represent 88.5%, while 11.5% are estimated to remain in need of services.

Among all age groups reported, the Child and Older Adult populations have an estimated unmet need for services in SA 3. Using Penetration Rate to conduct needs assessment Children served in SA 3 represent 26.0%, while 74.0% are estimated to remain in need of services and Older Adults served represent 81.6%, while 18.4% are estimated to remain in need of services.

FIGURE 27: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
RETENTION RATE BY ETHNICITY
FY 2010 - 2011 - SA 3

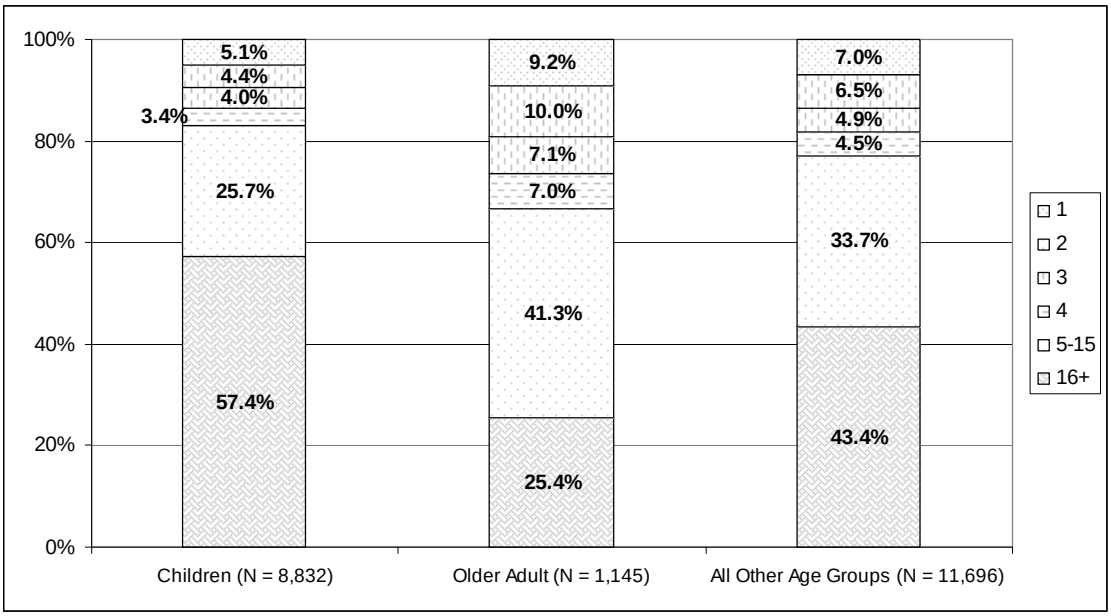


API=Asian/Pacific Islander. Retention Rate = Number of Outpatient Claims

Among the Asian/Pacific Islanders (API) that received Outpatient services in SA 3, 19% (5.1 + 5.0 + 4.8 + 4.1 = 19%) received four or fewer services; as compared to Latinos of which 20.1% (5.8 + 5.6 + 4.6 + 4.1 = 20.1%) received four or fewer services; and all other ethnic groups of which 22.9% (7.6 + 6.2 + 4.8 + 4.3 = 22.9%) received four or fewer services.

Among the Asian/Pacific Islanders (API) that received Outpatient Services in SA 3 38.5% received 5 to 15 services, and 42.5% received 16 or more; as compared to Latinos of which 30.4% received 5 to 15 services, and 49.5% received 16 or more; and all other ethnic groups of which 29.8% received 5 to 15 services, and 47.3% received 16 or more services.

FIGURE 28: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT: RETENTION RATE BY AGE GROUP FY 2010-2011 - SA 3



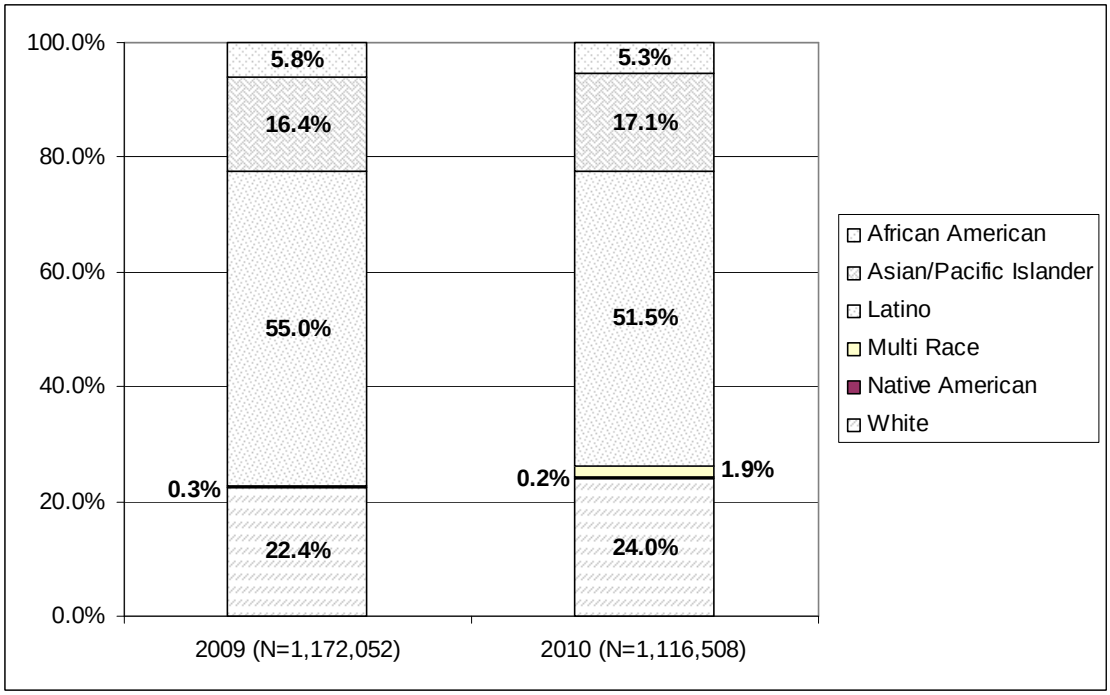
Retention Rate = Number of Outpatient Claims

Among Children that received Outpatient services in SA 3, 16.9% (5.1 + 4.4 + 4.0 + 3.4 = 16.9%) received four or fewer services; as compared to Older Adults of which 33.3% (9.2 + 10.0 + 7.1 + 7.0 = 33.3%) received four or fewer services; and all other age groups of which 22.9% (7.0 + 6.5 + 4.9 + 4.5 = 22.9%) received four or fewer services.

Among the Children 25.7% received 5 to 15 services, and 57.4% 16 or more services; as compared with the Older Adults of which 41.3% received 5 to 15 services, and 25.4% received 16 or more services; and all other age groups of which 33.7% received 5 to 15 services, and 43.4% received 16 or more services.

Service Area 4

FIGURE 29: TOTAL POPULATION BY ETHNICITY
CY 2009-2010 - SA 4



Note: Data for Multi Race is not available for 2009 population estimates.

FIGURE 30: TOTAL POPULATION BY AGE GROUP
CY 2009-2010 - SA 4

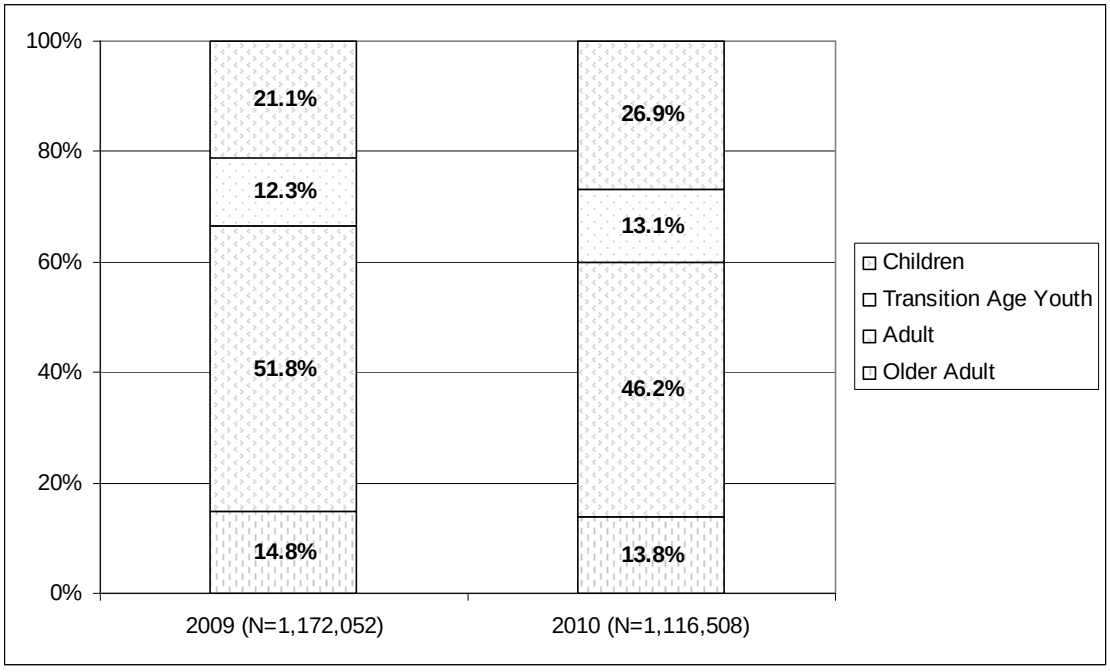
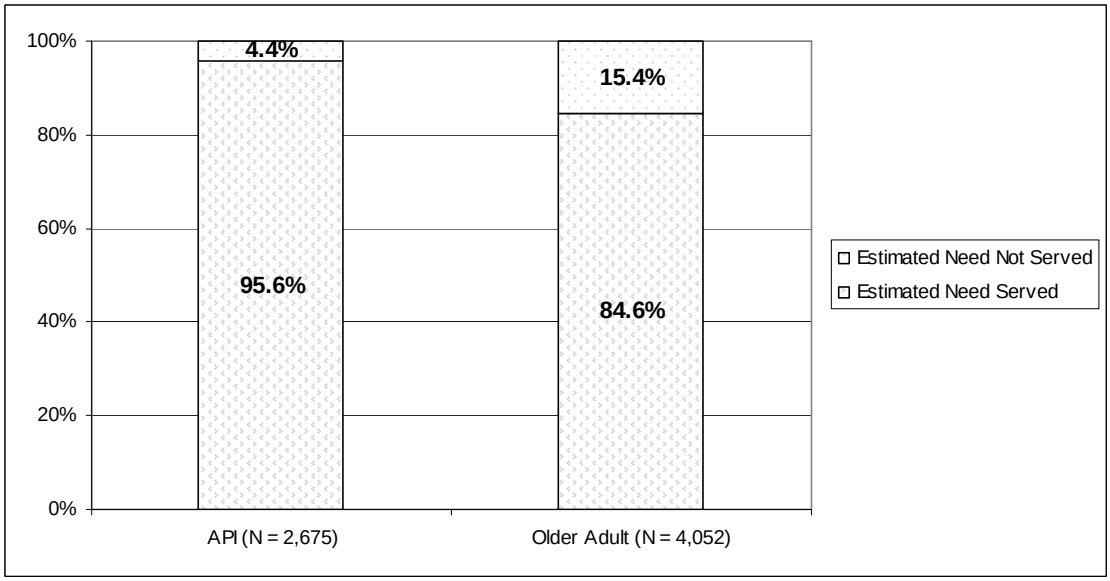


FIGURE 31: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT: PENETRATION RATE BY ETHNICITY AND AGE GROUP FY 2010-2011 - SA 4

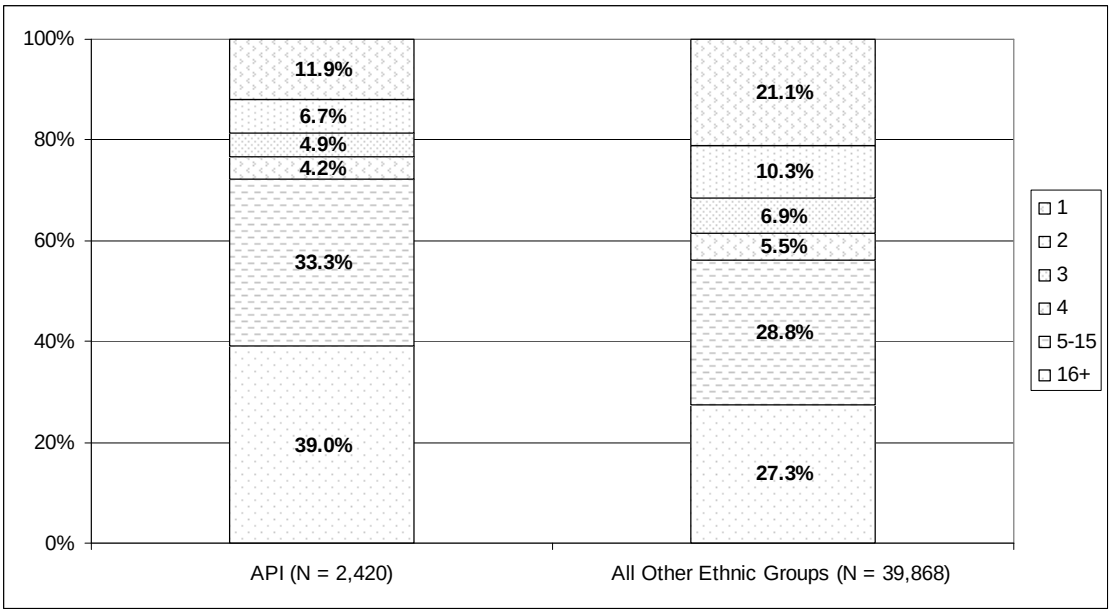


API=Asian/Pacific Islander

Among all ethnic groups reported, the Asian/Pacific Islander (API) population has an estimated unmet need for services in SA 4. The Penetration Rate is calculated as the proportion of Medi-Cal consumers served out of the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct needs assessment indicates API consumers served in SA 4 represent 95.6%, while 4.4% are estimated to remain in need of services.

Among all age groups reported, Older Adults have an estimated unmet need for services in SA 4. Using Penetration Rate to conduct a needs assessment indicates that Older Adults served in SA 4 represent 84.6%, while 15.4% are estimated to remain in need of services.

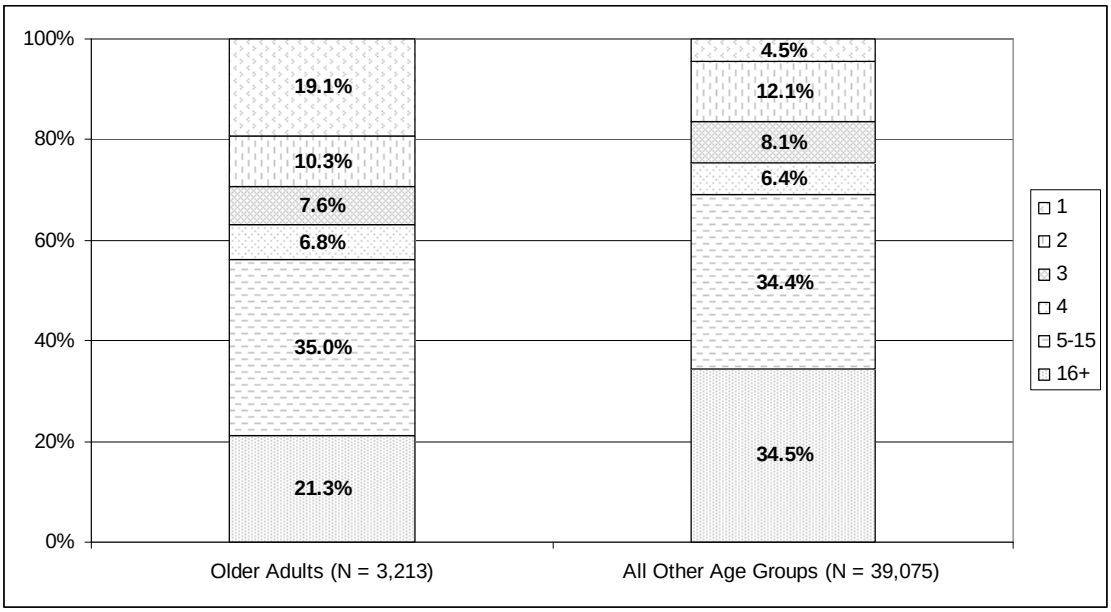
FIGURE 32: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
RETENTION RATE BY ETHNICITY
FY 2010-2011 - SA 4



API = Asian/Pacific Islander, Retention Rate = Number of Outpatient Claims

Among the Asian/Pacific Islanders (API) that received Outpatient services in SA 4, 27.7% (11.9 + 6.7 + 4.9 + 4.2 = 27.7%) received four or fewer services compared to 43.8% (21.1 + 10.3 + 6.9 + 5.5 = 43.8%) for all other ethnic groups; 33.3% received 5 to 15 services compared to 28.8% for all other ethnic groups; and 39.0% received 16 or more services compared to 27.3% for all other ethnic groups that received Outpatient services in SA 4.

FIGURE 33: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
RETENTION RATE BY AGE GROUP
FY 2010-2011 - SA 4

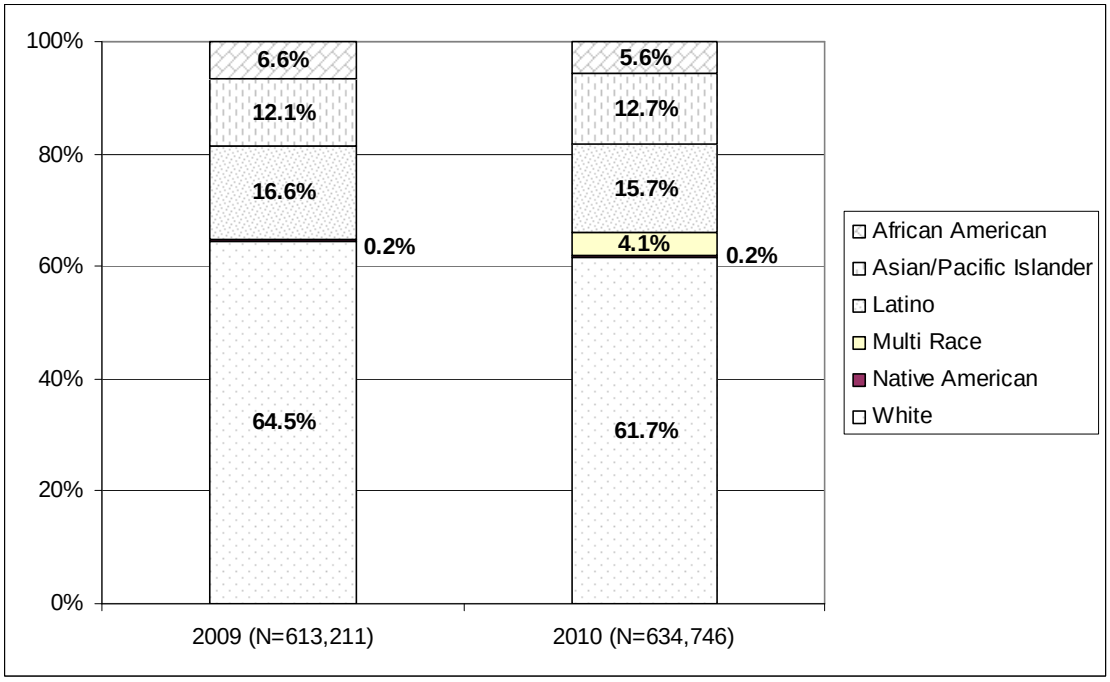


Retention Rate = Number of Outpatient Claims

Among the Older Adults that received Outpatient services in SA 4, 43.8% (19.1 + 10.3 + 7.6 + 6.8 = 43.8%) received four or fewer services compared to 31.1% (4.5 + 12.1 + 8.1 + 6.4 = 31.1%) for all other age groups; 35.0% received 5 to 15 services compared to 34.4% for all other age groups; and 21.3% received 16 or more services compared to 34.5% for all other age groups that received Outpatient services in SA 4.

Service Area 5

FIGURE 34: TOTAL POPULATION AND POPULATION BY ETHNICITY CY 2009-2010 - SA 5



Note: Data for Multi Race is not available for 2009 population estimates.

FIGURE 35: TOTAL POPULATION AND POPULATION BY AGE GROUP CY 2009-2010 - SA 5

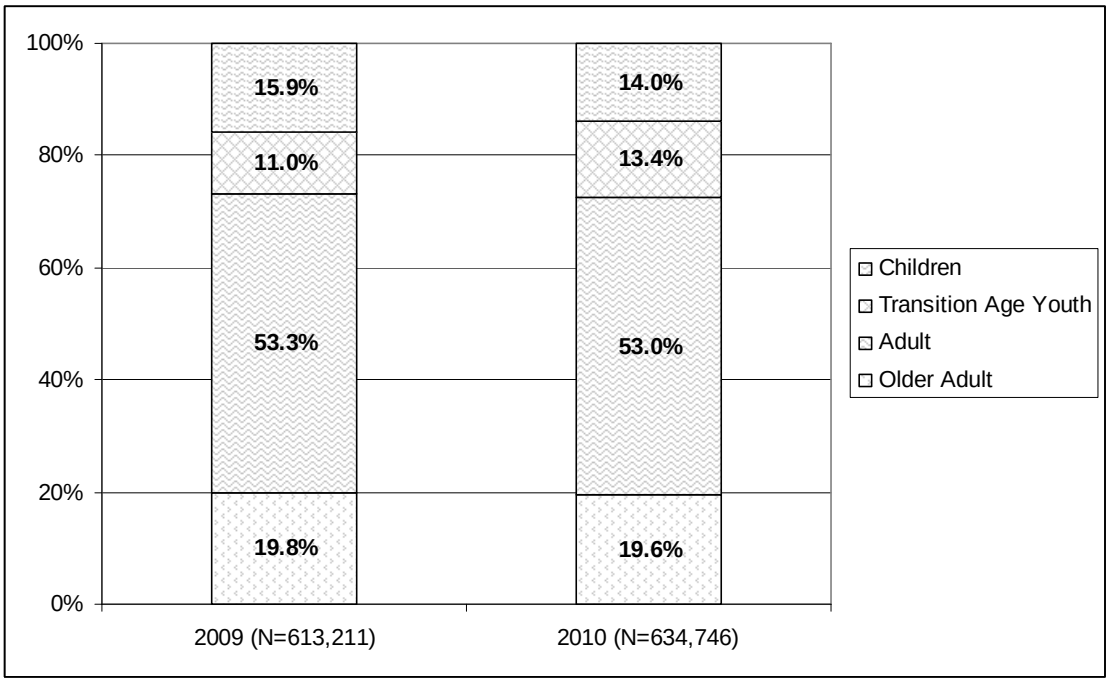
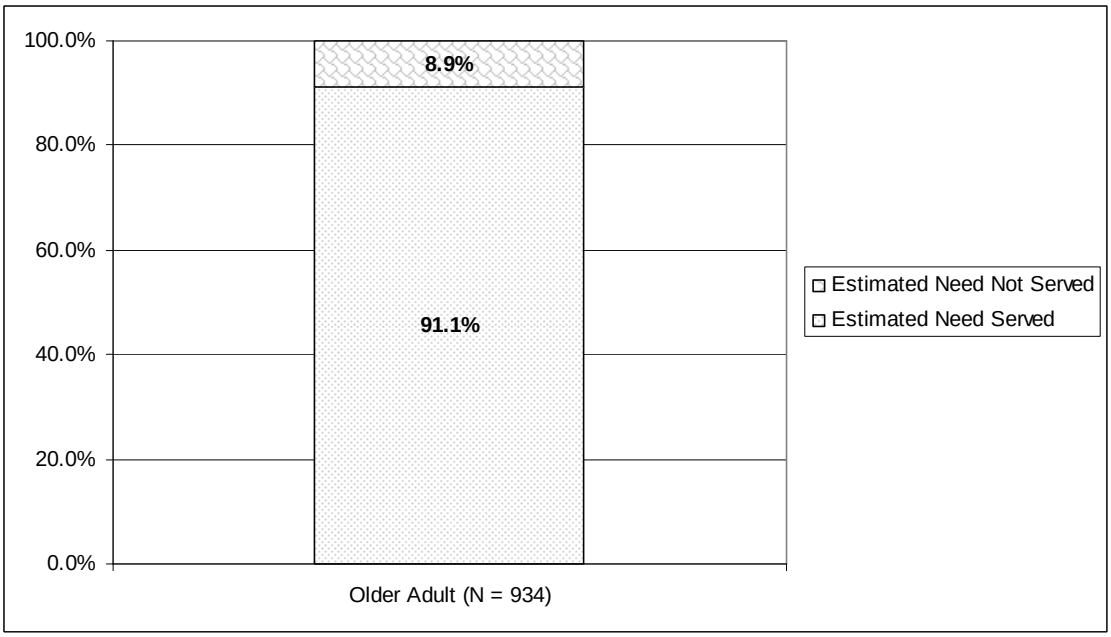


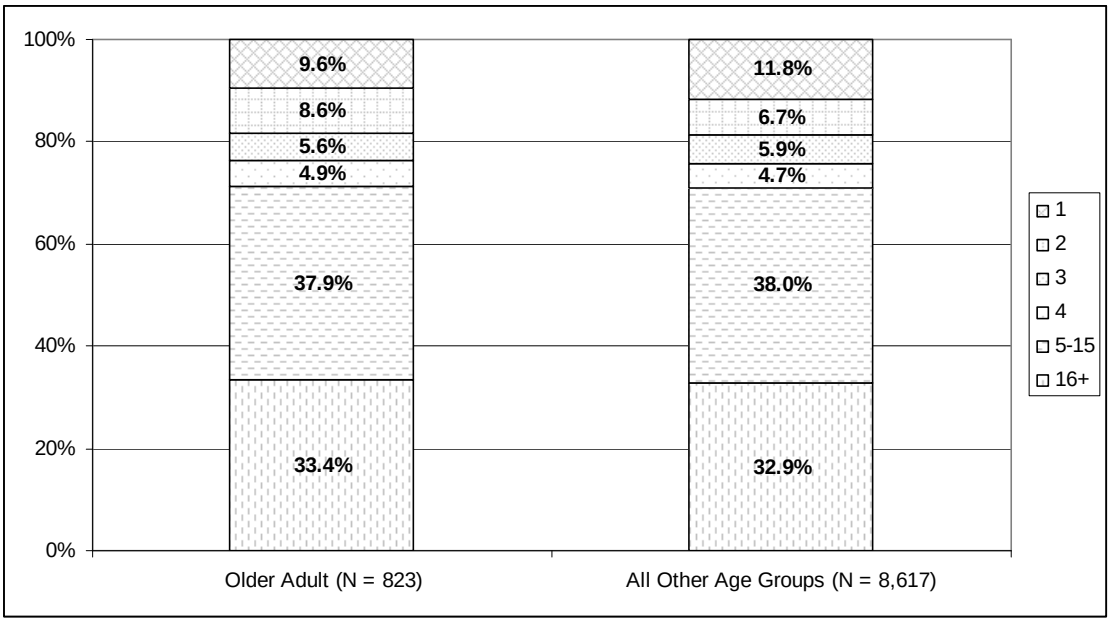
FIGURE 36: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT BY ETHNICITY[1] AND AGE GROUP FY 2010-2011 - SA 5



[1] SA 5 does not have an ethnic group that has estimated unmet need for services.

Among all ethnic and age groups reported, Older Adults have an estimated unmet need for services in SA 5. The Penetration Rate is calculated as the proportion of Medi-Cal consumers served out of the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct a needs assessment indicates that Older Adults served in SA 5, represent 91.1%, while 8.9% are estimated to remain in need of services.

FIGURE 37: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
RETENTION RATE BY AGE GROUP
FY 2010-2011 - SA 5

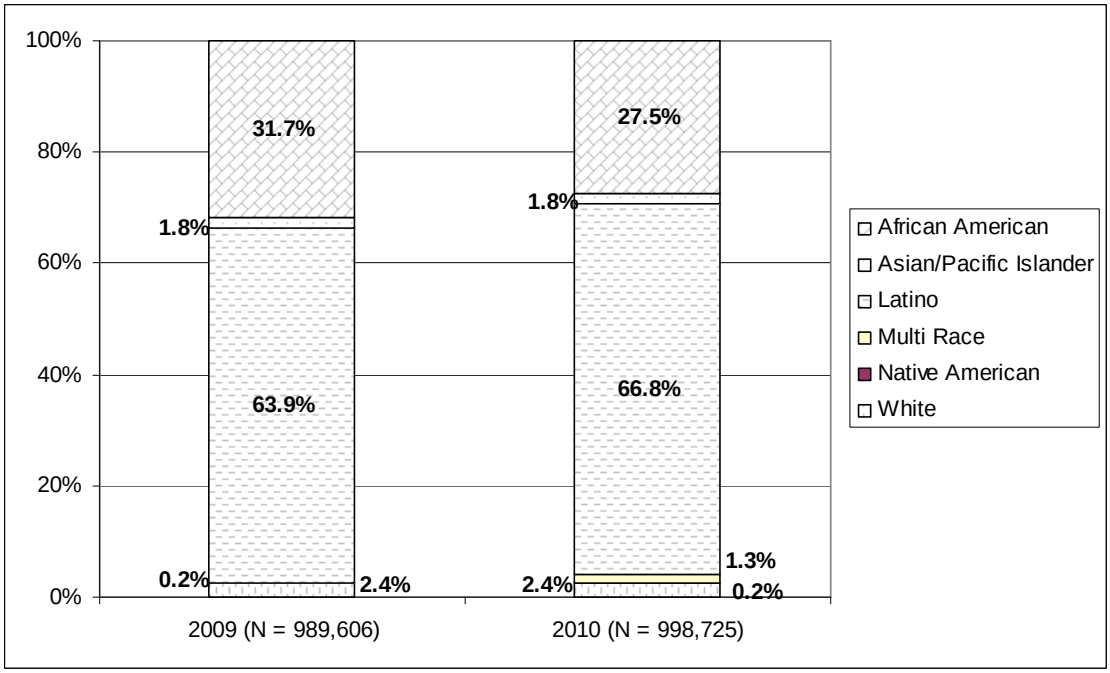


Retention Rate = Number of Outpatient Claims

Among the Older Adults that received Outpatient services in SA 5, 28.7% (9.6 + 8.6 + 5.6 + 4.9 = 28.7%) received four or fewer services compared to 29.1% (11.8 + 6.7 + 5.9 + 4.7 = 29.1%) for all other age groups; 37.9% received 5 to 15 services compared to 38.0% for all other age groups; and 33.4% received 16 or more services, compared to 32.9% for all other age groups that received Outpatient services in SA 5.

Service Area 6

FIGURE 38: TOTAL POPULATION BY ETHNICITY
CY 2009-2010 - SA 6



Note: Data for Multi Race is not available for 2009 population estimates.

FIGURE 39: TOTAL POPULATION BY AGE GROUP
CY 2009-2010 - SA 6

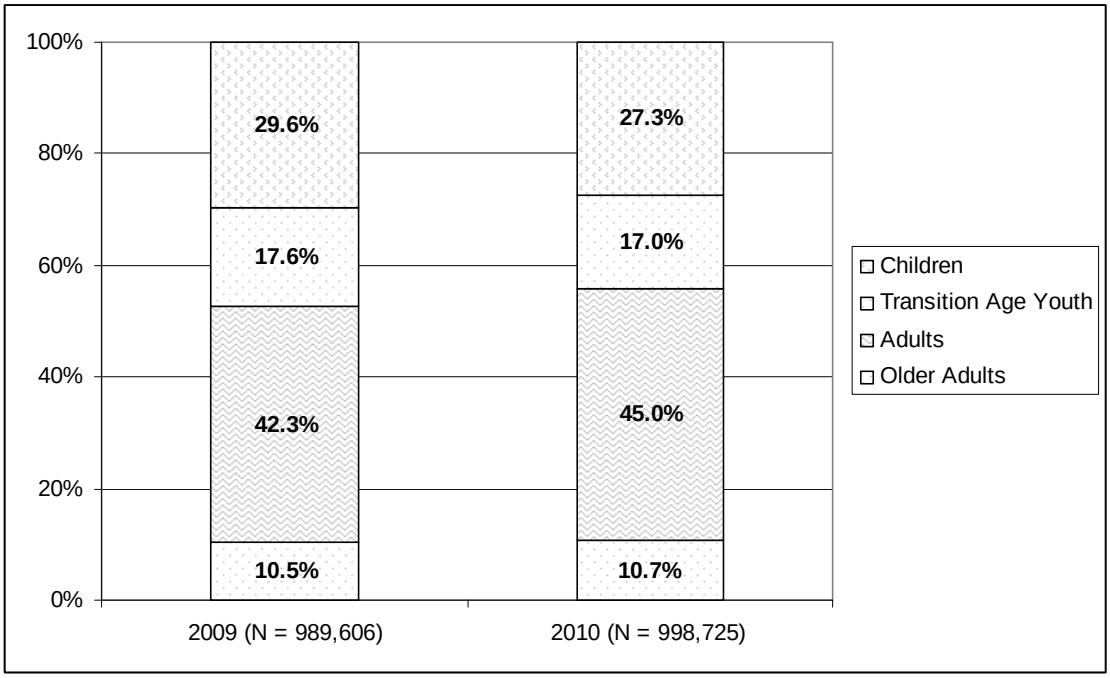
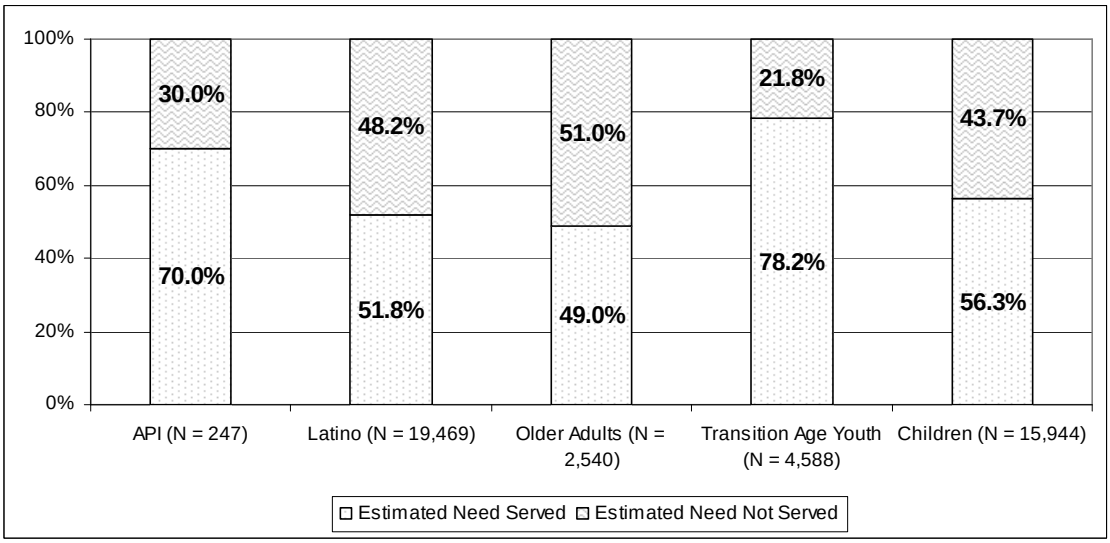


FIGURE 40: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT: PENETRATION RATE BY ETHNICITY AND AGE GROUP FY 2010-2011 - SA 6

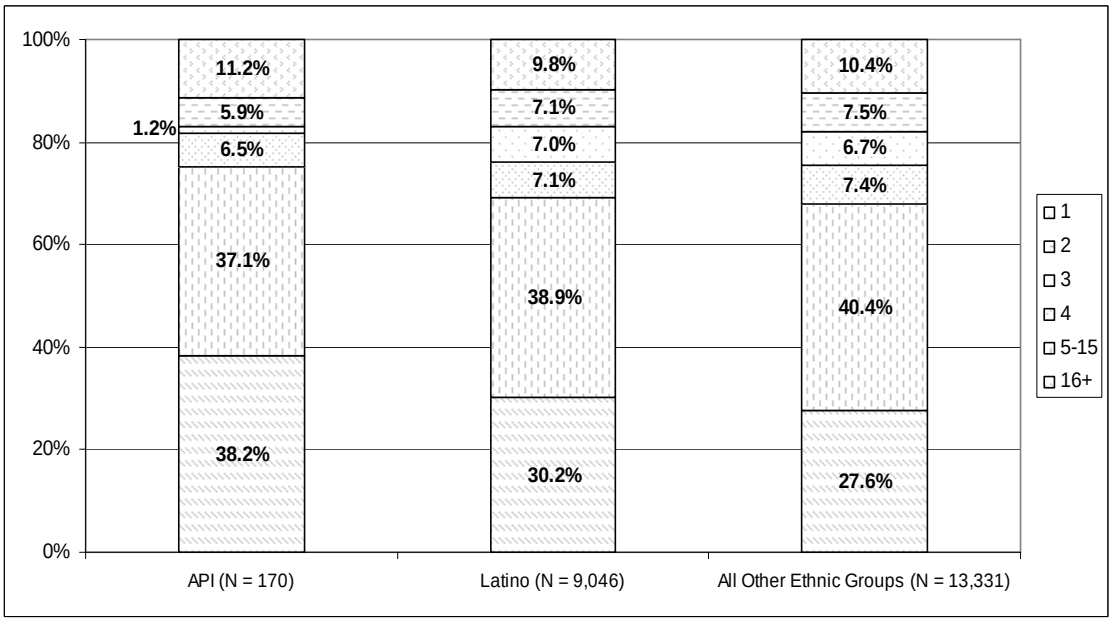


API=Asian/Pacific Islander

Among all ethnic and age groups reported, the Asian/Pacific Islander (API) population, the Latino population, Older Adults, TAY, and Children have estimated unmet need for services in SA 6. The Penetration Rate is calculated as the proportion of Medi-Cal consumers served out of the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI).

Using Penetration Rate to conduct a needs assessment indicates that API consumers served in SA 6 represent 70.0%, while 30.0% are estimated to remain in need of services; Latino consumers served in SA 6 represent 51.8%, while 48.2% are estimated to remain in need of services; Older Adults served in SA 6 represent 49.0%, while 51.0% are estimated to remain in need of services, TAY served in SA 6 represent 78.2% while 21.8% are estimated to remain in need of services; and Children served in SA 6 represent 56.3%, while 43.7% are estimated to remain in need of services.

FIGURE 41: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
RETENTION RATE BY ETHNICITY
FY 2010-2011 - SA 6

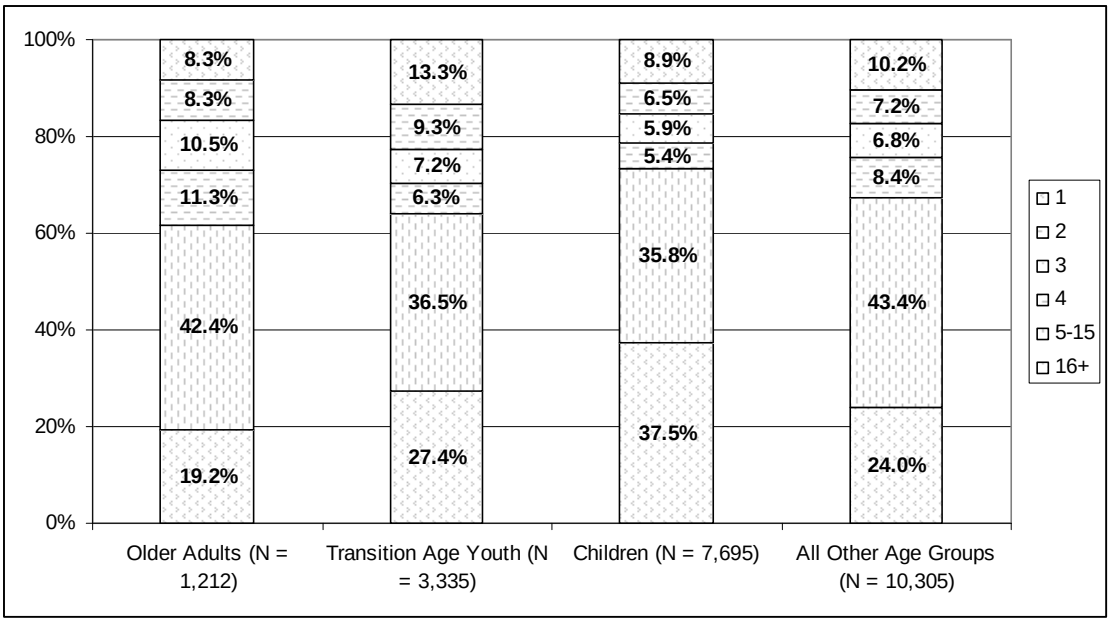


API=Asian/Pacific Islander, Retention Rate = Number of Outpatient Claims

Among the Asian/Pacific Islanders (API) that received Outpatient services in SA 6, 24.8% (11.2 + 5.9 + 1.2 + 6.5 = 24.8%) received four or fewer services, as compared to Latinos of which 31% (9.8 + 7.1 + 7.0 + 7.1 = 31%) received four or fewer services, and all other ethnic groups of which 32.0% (10.4 + 7.5 + 6.7 + 7.4 = 32.0%) received four or fewer services.

Among the Asian/Pacific Islanders (API) 37.1% received 5 to 15 services, and 38.2% received 16 or more services; as compared to Latinos of which 38.9% received 5 to 15 services, and 30.2% received 16 or more services; and all other ethnic groups of which 40.4% received 5 to 15 services, and 27.6% received 16 or more services.

FIGURE 42: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
RETENTION RATE BY AGE GROUP
FY 2010-2011 - SA 6



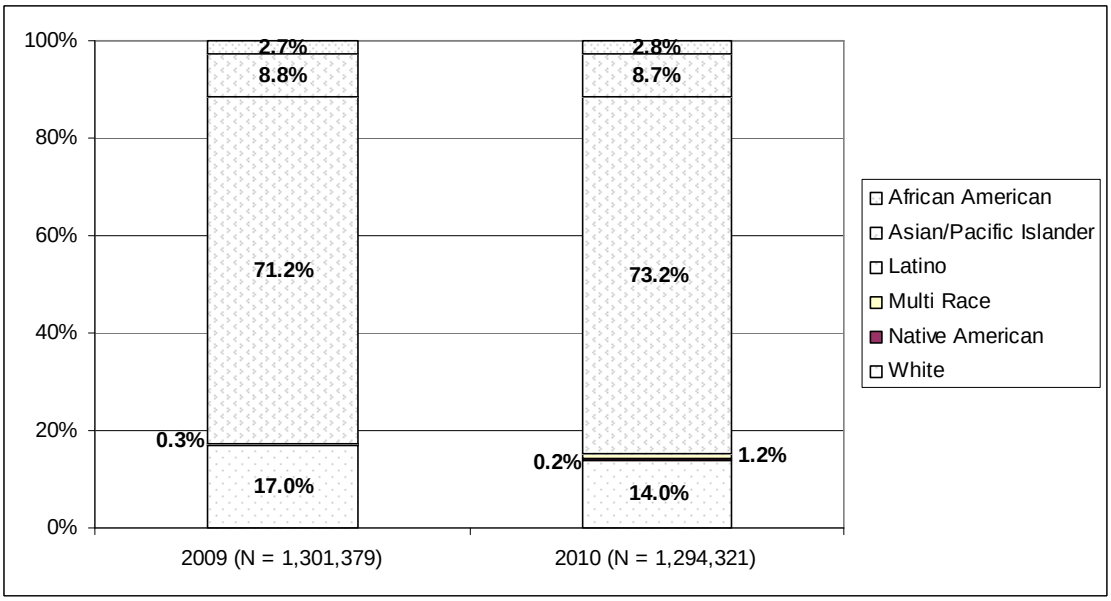
Retention Rate = Number of Outpatient Claims

Among Older Adults that received Outpatient services in SA 6, 38.4% (8.3 + 8.3 + 10.5 + 11.3 = 38.4%) received four or fewer services; compared to TAY of which 36.1% (13.3 + 9.3 + 7.2 + 6.3 = 36.1%) received four or fewer services; Children of which 26.7% (8.9 + 6.5 + 5.9 + 5.4 = 26.7%) received four or fewer services; and all other age groups of which 32.6% (10.2 + 7.2 + 6.8 + 8.4 = 32.6%) received four or fewer services.

Among the Older Adults 42.4% received 5 to 15 services, and 19.2% received 16 or more services; compared to TAY of which 36.5% received 5 to 15 services and 27.4% received 16 or more services; Children of which 35.8% received 5 to 15 services, and 37.5% received 16 or more services; and all other ethnic groups of which 43.4% received 5 to 15 services, and 24.0% received 16 or more services.

Service Area 7

FIGURE 43: TOTAL POPULATION BY ETHNICITY
CY 2009-2010 - SA 7



Note: Data for Multi Race is not available for 2009 population estimates.

FIGURE 44: TOTAL POPULATION BY AGE GROUP
CY 2009-2010 - SA 7

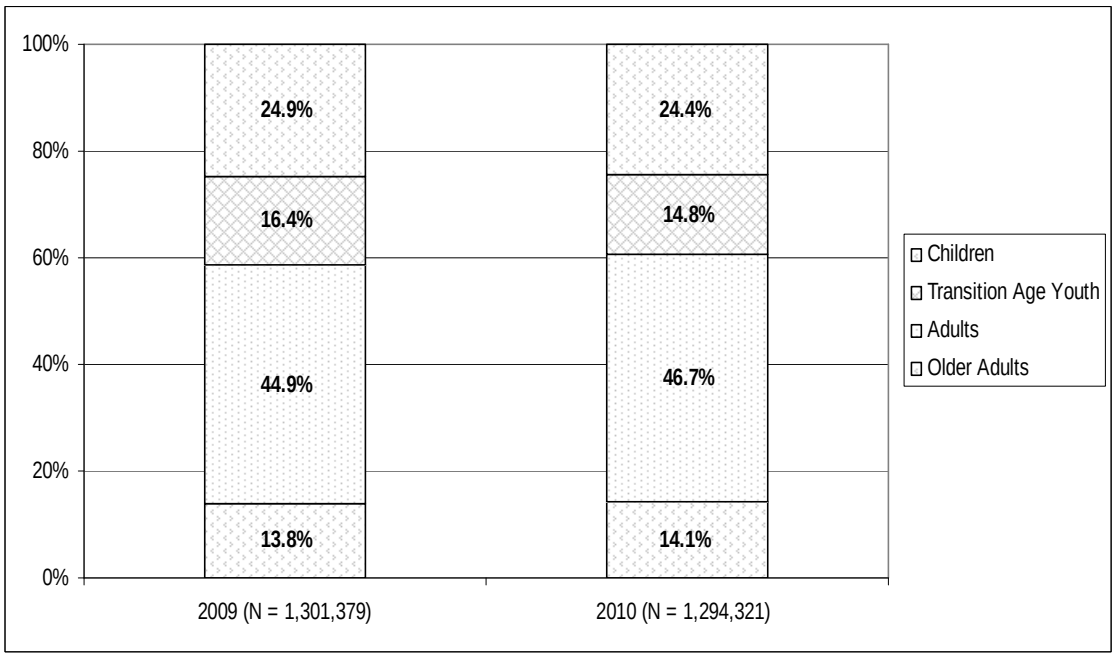
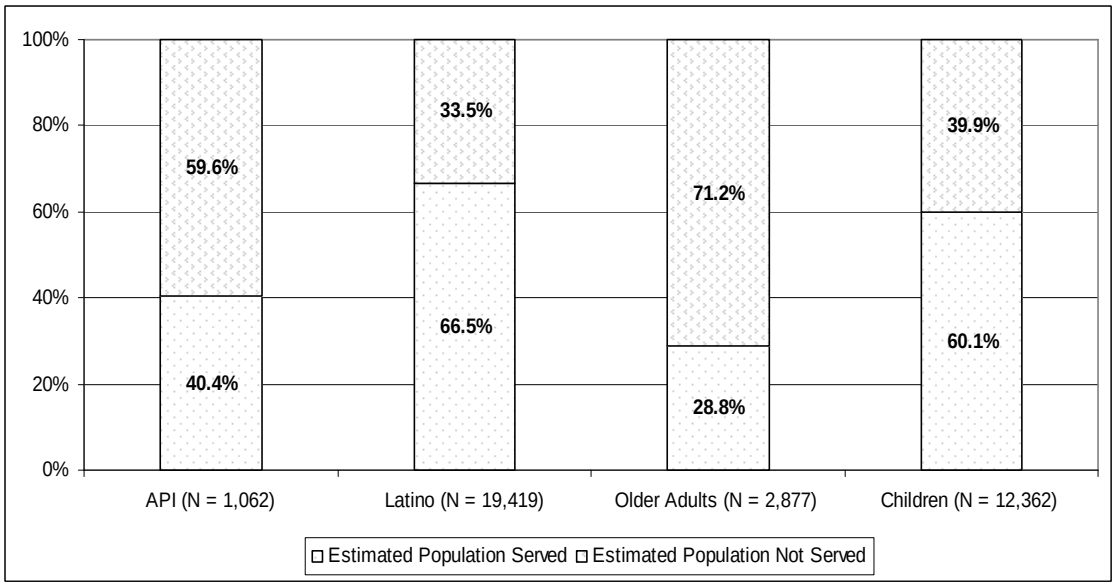


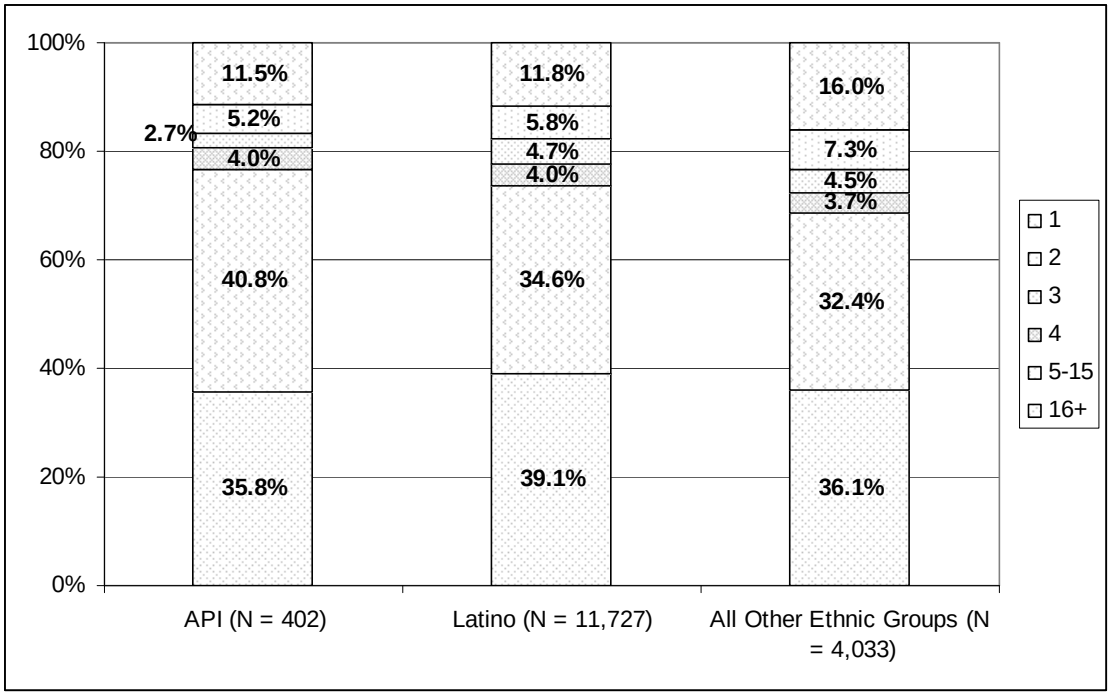
FIGURE 45: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT: PENETRATION RATE BY ETHNICITY AND AGE GROUP FY 2010 - 2011 - SA 7



API=Asian/Pacific Islander

Among all ethnic and age groups reported, the Asian/Pacific Islander (API) population, the Latino population, the Older Adult and Child populations have estimated unmet need for services in SA 7. The Penetration Rate is calculated as the proportion of Medi-Cal consumers served out of the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct a needs assessment indicates that API consumers served in SA 7 represent 40.4%, while 59.6% are estimated to remain in need of services; Latino consumers served in SA 7 represent 66.5%, while 33.5% are estimated to remain in need of services; Older Adult consumers served in SA 7 represent 28.8%, while 71.2% are estimated to remain in need of services; and Child consumers served represent 60.1%, while 39.9% are estimated to remain in need of services.

FIGURE 46: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT: RETENTION RATE BY ETHNICITY FY 2010-2011 - SA 7

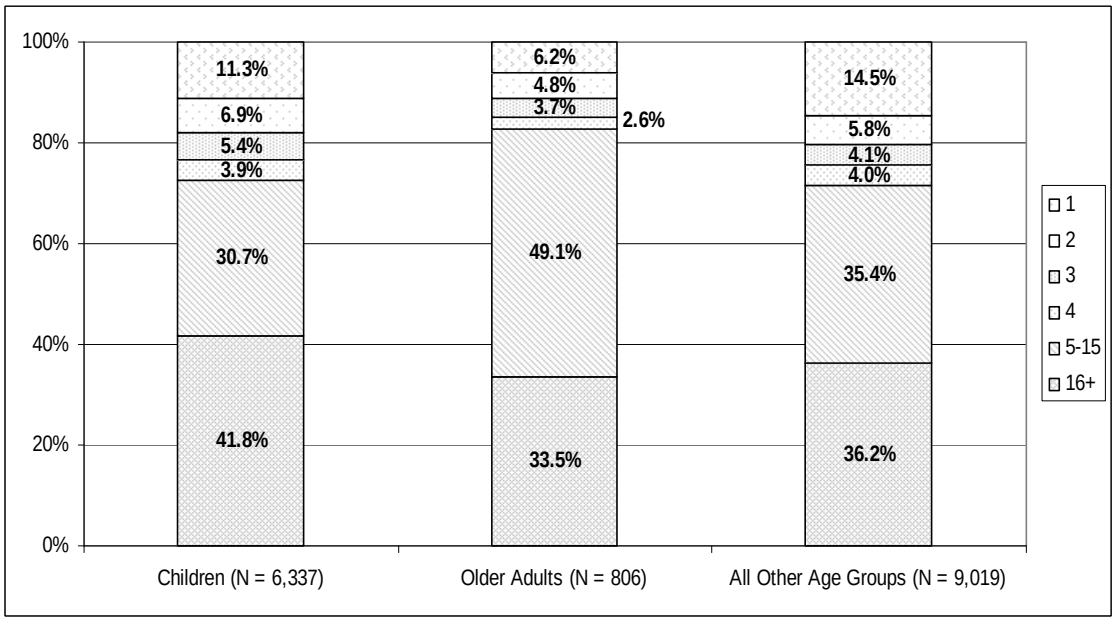


API=Asian/Pacific Islander, Retention Rate = Number of Outpatient Claims

Among the Asian/Pacific Islanders (API) that received Outpatient services in SA 7, 23.4% (11.5 + 5.2 + 2.7 + 4.0 = 23.4%) received four or fewer services, compared to Latinos of which 26.3% (11.8 + 5.8 + 4.7 + 4.0 = 26.3%) received four or fewer services, and all other ethnic groups of which 31.5% (16.0 + 7.3 + 4.5 + 3.7 = 31.5%) received four or fewer services.

Among the Asian/Pacific Islanders (API) 40.8% received 5 to 15 services, and 35.8% received 16 or more services; compared to Latinos of which 34.6% received 5 to 15 services, and 39.1% received 16 or more services; and all other ethnic groups of which 32.4% received 5 to 15 services, and 36.1% received 16 or more services.

FIGURE 47: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
RETENTION RATE BY AGE GROUP
FY 2010-2011 - SA 7



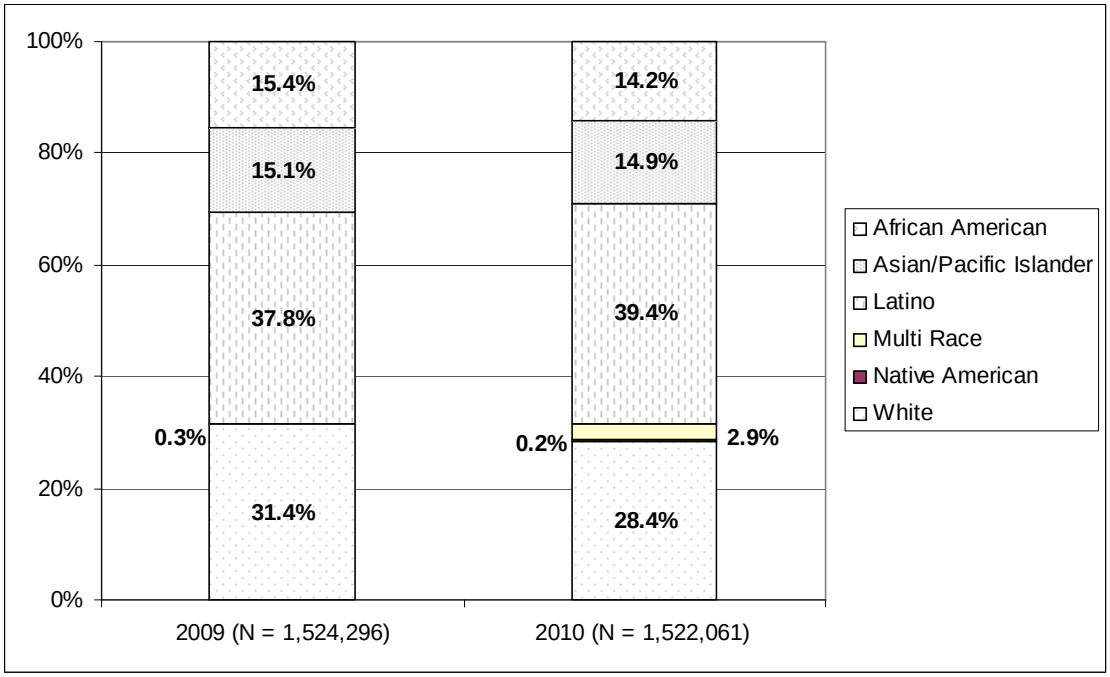
Retention Rate = Number of Outpatient Claims

Among the Children that received Outpatient services in SA 7, 27.5% (11.3 + 6.9 + 5.4 + 3.9 = 27.5%) received four or fewer services, compared to Older Adults of which 17.3% (6.2 + 4.8 + 3.7 + 2.6 = 17.3%) received four or fewer services, and all other age groups of which 28.4% (14.5 + 5.8 + 4.1 + 4.0 = 28.4%) received four or fewer services.

Among the Children 30.7% received 5 to 15 services, and 41.8% received 16 or more services; compared to Older Adults of which 49.1% received 5 to 15 services, and 33.5% received 16 or more services; and all other ethnic groups of which 35.4% received 5 to 15 services, and 36.2% received 16 or more services.

Service Area 8

FIGURE 48: TOTAL POPULATION BY ETHNICITY
CY 2009-2010 - SA 8



Note: Data for Multi Race is not available for 2009 population estimates.

FIGURE 49: TOTAL POPULATION BY AGE GROUP
CY 2009-2010 - SA 8

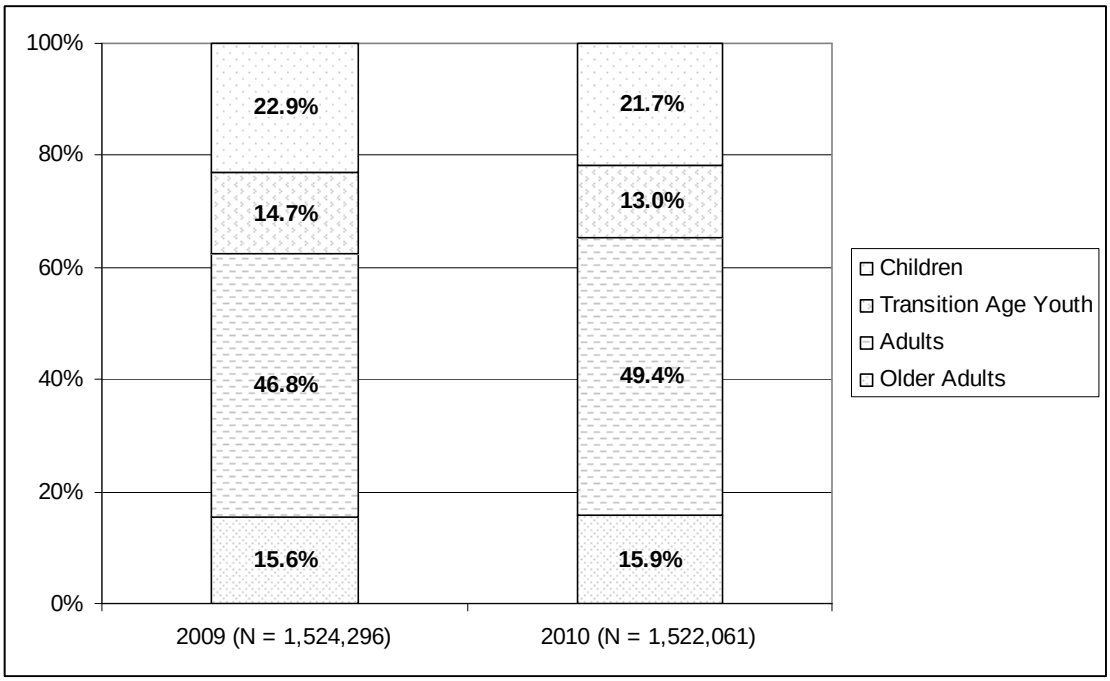
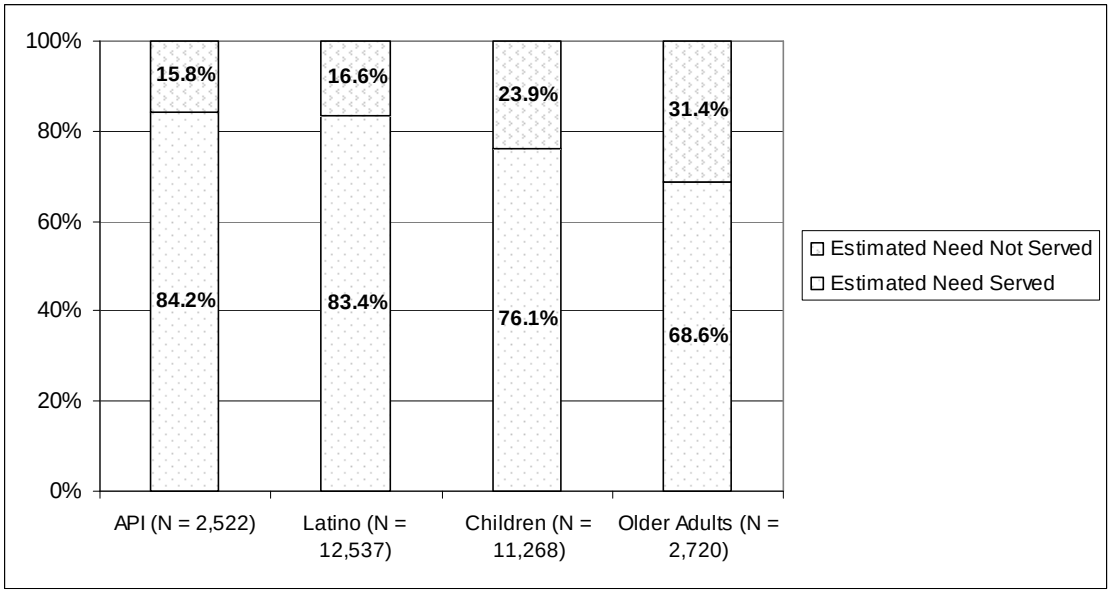


FIGURE 50: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT: PENETRATION RATE BY ETHNICITY AND AGE GROUP FY 2010-2011 - SA 8

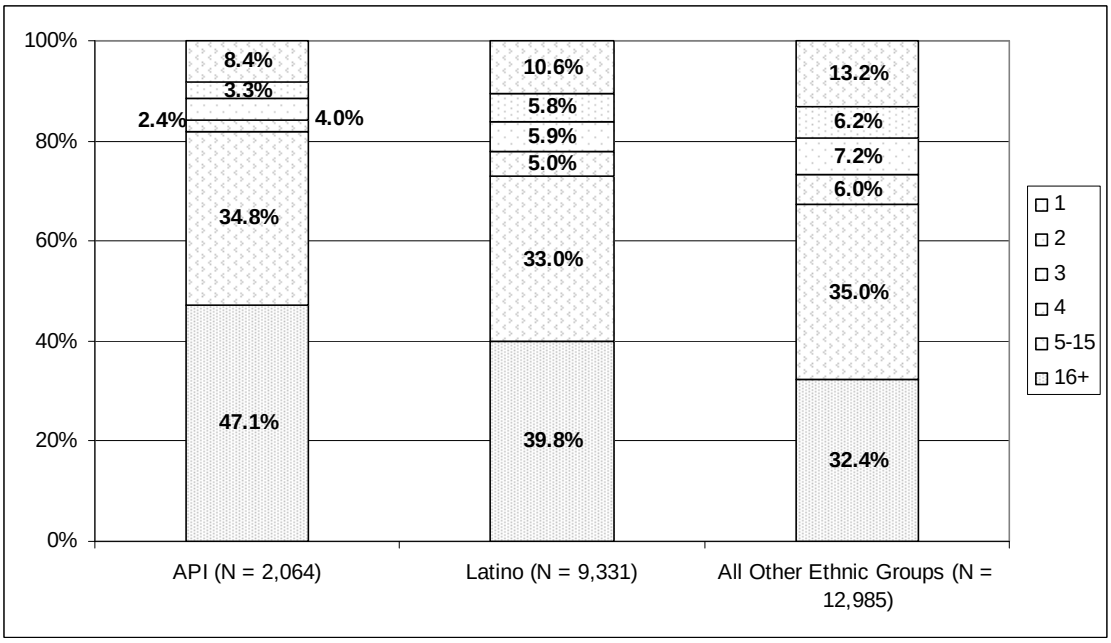


API=Asian/Pacific Islander

Among all ethnic and age groups reported, the Asian/Pacific Islander (API) population, the Latino population, the Older Adult population and the Child population have estimated unmet need for services in SA 8. The Penetration Rate is calculated as the proportion of Medi-Cal consumers served out of the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI).

Using Penetration Rate to conduct a needs assessment indicates that API consumers served in SA 8 represent 84.2%, while 15.8% are estimated to remain in need of services; Latino consumers served in SA 8 represent 83.4%, while 16.6% are estimated to remain in need of services; Child consumers served in SA 8 represent 76.1%, while 23.9% are estimated to remain in need of services; and Older Adult consumers served in SA 8 represent 68.6%, while 31.4% are estimated to remain in need of services.

FIGURE 51: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT:
RETENTION RATE BY ETHNICITY
FY 2010-2011 - SA 8

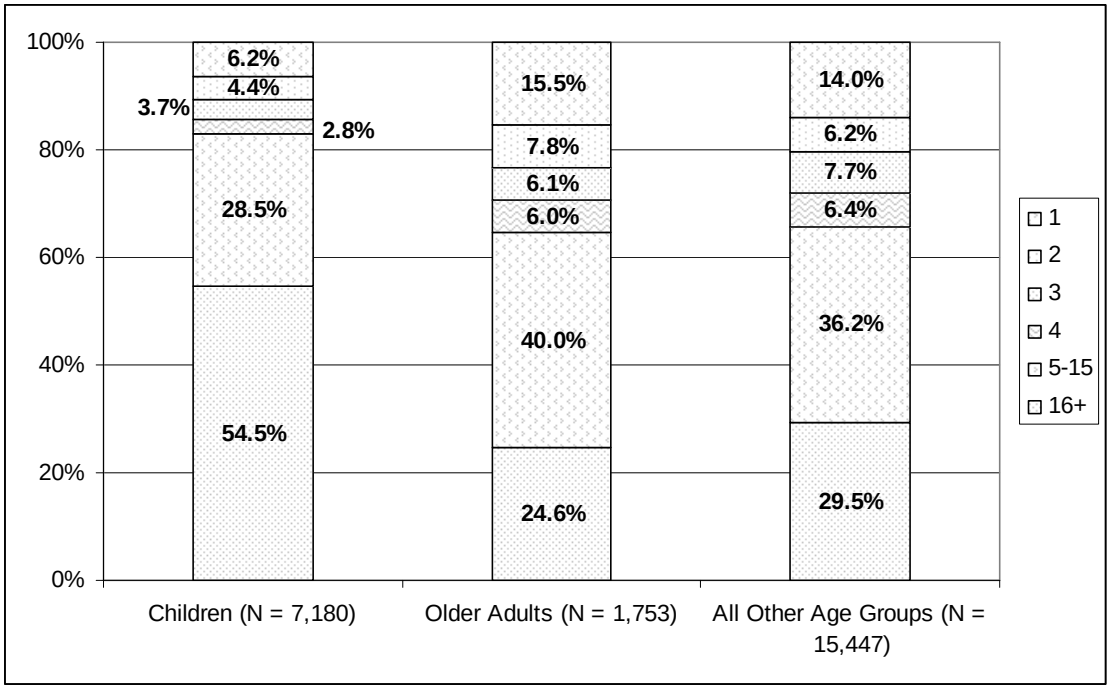


API = Asian/Pacific Islander, Retention Rate = Number of Outpatient Claims

Among the Asian/Pacific Islanders (API) that received Outpatient services in SA 8, 18.1% (8.4 + 3.3 + 4.0 + 2.4 = 18.1%) received four or fewer services; compared to Latinos of which 27.3% (10.6 + 5.8 + 5.9 + 5.0 = 27.3%) received four or fewer services; and all other ethnic groups of which 32.6% (13.2 + 6.2 + 7.2 + 6.0 = 32.6%) received four or fewer services.

Among the Asian/Pacific Islanders (API) 34.8% received 5 to 15 services, and 47.1% received 16 or more services; compared to Latinos of which 33.0% received 5 to 15 services, and 39.8% received 16 or more services; and all other ethnic groups of which 35.0% received 5 to 15 services, and 32.4% received 16 or more services.

FIGURE 52: SUMMARY DEMOGRAPHIC NEEDS ASSESSMENT: RETENTION RATE BY AGE GROUP FY 2010-2011-SA 8



Retention Rate = Number of Outpatient Claims

Among the Children that received Outpatient services in SA 8, 17.1% (6.2 + 4.4 + 3.7 + 2.8 = 17.1%) received four or fewer services; compared to Older Adults of which 35.4% (15.5 + 7.8 + 6.1 + 6.0 = 35.4%) received four or fewer services; and all other age groups of which 34.3% (14.0 + 6.2 + 7.7 + 6.4 = 34.3%) received four or fewer services.

Among the Children 28.5% received 5 to 15 services, and 54.5% received 16 or more, compared to Older Adults of which 40.0% received 5 to 15 services, and 24.6% received 16 or more services; and all other ethnic groups of which 36.2% received 5 to 15 services, and 29.5% 16 or more services.

SECTION 3

QI WORK PLAN EVALUATION REPORT FOR CY 2011

LACDMH provides a full array of treatment services as required under W&IC Sections 5600.3, State Medi-Cal Oversight Review Protocols. The QI Work Plan Goals are in place to continuously improve the quality of the service delivery system. In accordance with State standards, the LACDMH evaluation of Quality Improvement activities are structured and organized according to the following:

1. Monitoring Service Delivery Capacity
2. Monitoring Accessibility of Services
3. Monitoring Beneficiary Satisfaction
4. Monitoring Clinical Care
5. Monitoring Continuity of Care
6. Monitoring of Provider Appeals

SUMMARY OF QI WORK PLAN GOALS FOR CY 2011

The QI Work Plan Goals for 2011, within the 6 broad domains identified above, define specific goals for particular activities. Each of these activities pertains to key functions carried out by LACDMH in addressing the Mental Health needs of the community. These specific goals, which are outlined in the QI Work Plan for CY 2011 presented below, include monitoring access to services for under-represented populations, timeliness of services, language needs of consumers, consumers' satisfaction with services, and other goals as identified by the LACDMH.

Consistent with the Federal Block Grant and State Performance Contract, the LACDMH selects performance indicators for their relevance, feasibility, scientific validity, and meaningful value in improving the lives of consumers, families, and stakeholders of mental health services. A uniform set of performance indicators are utilized to ensure accountability and effectiveness of the quality and quantity of community and hospital based services. The selected measures are also consistent with national and standardized empirically-derived performance indicators from the 16-State Study (Lutterman, et al. 2003) and recommendations from the National Association of State Mental Health Program Directors Research Institute (NASMHPD).

In the Work Plan Evaluation which follows, the extent to which LACDMH has reached each stipulated goal is evaluated.

QUALITY IMPROVEMENT WORK PLAN CY 2011

I. MONITORING SERVICE DELIVERY CAPACITY

1. a. The Penetration Rate for Latinos below the 200% Federal Poverty Level (FPL) will be maintained at 45%.

b. The Retention Rate for Latinos will be maintained at 44.6% for 5-15 services and at 52% for 16 or more services.

c. The Penetration Rate for Asian/Pacific Islanders below the 200% Federal Poverty Level (FPL) will be increased by 0.2% from 28.3% to 28.5%.

d. The Retention Rate for Asian/Pacific Islanders (API) will be maintained at 4.3% for 5-15 services and at 4.7% for 16 or more services.

2. The Cultural Competency Unit, the Cultural Competency Committee, the Quality Improvement Council, and the Service Area Quality Improvement Committees will collaboratively identify and select strategies and interventions to improve the API Penetration Rate (for the Population at or below 200% poverty) which has decreased by 3.2% between 2007 and 2010.

II. MONITORING ACCESSIBILITY OF SERVICES

1. Maintain access to after-hours care at 69% of PMRT response time of one hour between PMRT acknowledgements of the call to PMRT arrival on the scene and continue year to year trending.

2. Maintain the rate of abandoned calls (responsiveness of the 24-hour toll free number) at an overall annual rate of 15%.

3. Increase the overall rate by 1% from 88.7% in CY 2010 to 89.7% in CY 2011 for consumers/families reporting that they are able to receive services at convenient locations and continue year to year trending. [Source: Performance Outcomes].

4. Increase the overall rate by 1% from 90.7% in CY 2010 to 91.7% in CY 2011 for consumer/families reporting that they are able to receive services at convenient times and continue year to year trending. [Source: Performance Outcomes].

III. MONITORING BENEFICIARY SATISFACTION

1. Continue to participate with CDMH new survey methodology (once a year) for the Statewide Performance Outcomes, determine improved survey sampling methodology, and continue year to year trending.

2. Increase by 1% from 90% in CY 2010 to 91% in CY 2011 consumers/families reporting that staff were sensitive to cultural/ethnic background [Source: Performance Outcomes].

3. Increase by 1% from 84.4% in CY 2010 to 85.4% in CY 2011 the Overall Satisfaction Percentage Score and initiate year to year trending. [Source: Performance Outcomes]

4. Maintain at 94% consumers/families reporting that written materials are available in their preferred language and continue year to year trending.

5. Continue to identify areas for improvement for Service Area QICs for use in quality improvement activities, and increase Service Area Quality Improvement Projects from 2 to 4.

6. Continue to Monitor and improve beneficiary grievances, appeals and State Fair Hearings processes, including instituting new electronic system and annual reporting for policy changes.

7. Continue to improve responsiveness to Beneficiary Requests for Change of Provider. Continue to monitor reports on the reasons given by consumers for their change of provider request and integrate measures into the new electronic system.

IV. MONITORING CLINICAL CARE

1. Continue to improve medication practices through systematic use of medication protocols and trainings for the use of medication forms and clinical documentation for existing staff and for new staff.

2. Continue EPSDT Performance Improvement Project (PIP) to ensure that each consumer receives services that are appropriate, effective and efficient.

V. MONITORING CONTINUITY OF CARE

1. Consumers will receive continuity of care by being seen within 7 calendar days of discharge from an acute psychiatric hospital (Post Hospitalization Outpatient Access – PHOA) and continue RC2 PIP in collaboration with APS/EQRO and Statewide consultants.

VI. MONITORING OF PROVIDER APPEALS

1. Continue monitoring the rate of zero appeals through CY 2011.

I. MONITORING SERVICE DELIVERY CAPACITY

Goal I.1.

- ***a. The Penetration Rate for Latinos below the 200% Federal Poverty Level (FPL) will be maintained at 45%.***
- ***b. The Retention Rate for Latinos will be maintained at 44.6% for 5-15 services and at 52% for 16 or more services.***
- ***c. The Penetration Rate for Asian/Pacific Islanders below the 200% Federal Poverty Level will be increased by 0.2% from 28.3% to 28.5%.***
- ***d. The Retention Rate for Asian/Pacific Islanders will be maintained at 4.3% for 5-15 services and at 4.7% for 16 or more services.***

Penetration Rate Numerator: Unduplicated number of consumers served (in a category) during the fiscal year.

Penetration Rate Denominator: County population in each of the reporting categories estimated with SMI and SED.

Retention Rate Numerator: Number of consumers receiving given number of services (or claims).

Retention Rate Denominator: Total number of consumers receiving services (approved claims).

EVALUATION

The Penetration goals for the Latino population have been exceeded; however the Retention goals for the Latino population have been partially met. The Penetration and Retention goals for the Asian/Pacific Islander (API) population have been exceeded.

A primary goal of the LACDMH is to foster accessibility of services to under-served populations. In the County of Los Angeles, the largest ethnic groups regarded as underserved are the Latino and API populations. LACDMH is committed to addressing the barriers to services affecting these ethnic groups in particular, but also barriers to all underserved target populations.

The LACDMH utilizes Penetration (Service Utilization) Rates to address the fundamental accessibility of mental health services to the identified target populations. This national measure monitors systems for their responsiveness to the different types of populations for which they are responsible and serves as the primary rationale for using this indicator. This indicator and Retention Rates help determine the disparities and set goals for improvement.

As part of its commitment to addressing disparities in services, the LACDMH is moving toward developing more sensitive measures of disparity. As a first step,

both Penetration and Retention measures are used to analyze and understand disparities. For example, a high level of Penetration for a given population may have a corresponding low level of Retention. Likewise, a low level of Penetration may have a corresponding high level of Retention. In what follows Penetration and Retention tables and graphs are presented for the Service Areas and countywide to provide preliminary Disparity data. Clearly the issues related to disparities are very complex and the Tables and Figures presented below are first steps in understanding this data.

(For the analysis below, please refer to Table 24 and 25 for Penetration and Retention Data, as well as Figures 69 and 70 for Countywide Penetration and Retention Rates for populations below 200% Federal Poverty.)

a. The Penetration Rate for the Latino Population Estimated with SED & SMI has increased to 27.5% in FY 10-11. The Penetration Rate for the Latino population living below 200% FPL and Estimated with SED & SMI has increased to 53.0% in FY 10-11, exceeding the goal set for this population.

b. The Penetration Rate for the API Population Estimated with SED & SMI has increased to 13.0% in FY 10-11. The Penetration Rate for the API population living below 200% FPL and Estimated with SED & SMI has increased to 38.6% in FY 10-11, exceeding the goal set for this population.

c. The Latino Retention Rate for 5-15 services increased by 0.3% from 44.6% in FY 09-10 to 44.9% in FY 10-11. The Retention Rate for 16 or more services decreased by 1.4% from 52.0% in FY 09-10 to 50.6% in FY 10-11. The goal of maintaining the Retention Rate for 5-15 services at 44.6% was met and exceeded, however the goal of maintaining the Retention Rate for 16 or more services at 52% was not met.

d. The API Retention Rate for 5-15 services increased by 0.7% from 4.3% in FY 09-10 to 5.0% in FY 10-11. The Retention Rate for 16 or more services increased by 0.7% from 4.7% in FY 09-10 to 5.4% in FY 10-11. The goal of maintaining the Retention Rate for 5-15 services at 4.3% was met and exceeded and the goal of maintaining the Retention Rate for 16 or more services at 4.7% was met and exceeded as well.

Disparities by Service Area

Disparities are defined using demographic data specific to each Service Area. Strategies are matched where unmet needs are estimated to exist using Penetration Rates by Service Area for Estimated SED/SMI Populations Enrolled in Medi-Cal.

The following are specific populations with estimated unmet needs by Service Area:

SA 1: API, Older Adults and populations speaking the threshold language of Spanish.

SA 2: API, Latinos, Women, Children, Older Adults, and populations speaking the threshold languages of Armenian, Farsi, Korean, Russian, Spanish and Tagalog.

SA 3: API, Latinos, Women, Children, Older Adults and populations speaking the threshold languages of Armenian, Cantonese, Mandarin, Spanish and Vietnamese.

SA 4: API, Older Adults and populations speaking the threshold languages of Armenian, Cantonese, Korean, Russian and Tagalog.

SA 5: Older Adults is the only population with estimated unmet need.

SA 6: API, Latinos, Men, Women, Children, TAY, Older Adults and Spanish speaking populations have estimated unmet need.

SA 7: API, Latinos, Men, Women, Children, Older Adults and populations speaking the threshold language of Spanish.

SA 8: API, Latinos, Children, Older Adults and populations speaking the threshold language of Spanish.

By Age Group: Older Adults are estimated to be underserved in all Service Areas. Children are estimated to be underserved in Service Areas 2, 3, 6, 7, and 8. TAY are estimated to be underserved in Service Area 6.

By Ethnicity: API and Latinos are estimated to be underserved in all Service Areas except SA 5.

By Gender: Women are estimated to be underserved in Service Areas 2 and 3, men and women are estimated to be underserved in Service Areas 6 and 7.

This emphasizes the need for increasing access to mental health services for Older Adults, API, Latinos and Children as well as for other demographic groups such as Women, Men and TAY.

TABLE 24: PENETRATION RATE FOR SED AND SMI POPULATION
FY 10-11

Ethnicity by Service Area (SA)	Number of Consumers Served	Population Estimated with SED & SMI	Penetration Rate for Total Population Estimated with SED & SMI	Population Estimated with SED & SMI AND Living at or Below 200% FPL	Penetration Rates for Population Living at or Below 200% FPL and Estimated with SED & SMI
SA 1					
African American	4,232	3,963	106.8%	1,820	232.5%
Asian/Pacific Islander	127	720	17.6%	228	55.7%
Latino	4,666	11,906	39.2%	4,252	109.7%
Native American	65	125	52.0%	71	91.5%
White	2,769	7,853	35.3%	2,317	119.5%
Total	11,859	24,567	48.3%	8,688	136.5%
SA 2					
African American	4,119	5,095	80.8%	1,971	209.0%
Asian/Pacific Islander	1,042	11,280	9.2%	2,937	35.5%
Latino	15,125	57,969	26.1%	27,269	55.5%
Native American	131	306	42.8%	156	84.0%
White	10,600	55,923	19.0%	12,317	86.1%
Total	31,017	130,573	23.8%	44,650	69.5%
SA 3					
African American	3,402	4,399	77.3%	2,046	166.3%
Asian/Pacific Islander	1,948	23,251	8.4%	8,228	23.7%
Latino	14,440	56,126	25.7%	24,656	58.6%
Native American	117	235	49.8%	110	106.4%
White	4,429	22,165	20.0%	4,991	88.7%
Total	24,336	106,176	22.9%	40,031	60.8%
SA 4					
African American	13,844	4,131	335.1%	1,569	882.3%
Asian/Pacific Islander	2,881	9,338	30.9%	4,288	67.2%
Latino	25,434	40,270	63.2%	28,899	88.0%
Native American	285	164	173.8%	88	323.9%
White	10,028	16,084	62.3%	4,464	224.6%
Total	52,472	69,987	75.0%	39,308	133.5%

TABLE 24 (Contd.): PENETRATION RATE FOR SED AND SMI POPULATION FY 10-11

Ethnicity by Service Area (SA)	Number of Consumers Served	Population Estimated with SED & SMI	Penetration Rate for Total Population Estimated with SED & SMI	Population Estimated with SED & SMI AND Living at or Below 200% FPL	Penetration Rates for Population Living at or Below 200% FPL and Estimated with SED & SMI
SA 5					
African American	3,954	2,487	159.0%	749	527.9%
Asian/Pacific Islander	345	3,960	8.7%	1,044	33.0%
Latino	3,305	6,984	47.3%	2,882	114.7%
Native American	48	76	63.2%	26	184.6%
White	4,824	23,483	20.5%	4,119	117.1%
Total	12,476	36,990	33.7%	8,820	141.5%
SA 6					
African American	15,807	19,258	82.1%	10,358	152.6%
Asian/Pacific Islander	269	871	30.9%	420	64.0%
Latino	12,275	46,701	26.3%	31,234	39.3%
Native American	57	114	50.0%	39	146.2%
White	1,661	1,441	115.3%	492	337.6%
Total	30,069	68,385	44.0%	42,543	70.7%
SA 7					
African American	3,021	2,562	117.9%	1,029	293.6%
Asian/Pacific Islander	538	5,507	9.8%	1,728	31.1%
Latino	16,697	66,297	25.2%	31,828	52.5%
Native American	262	211	124.2%	106	247.2%
White	2,937	10,843	27.1%	2,667	110.1%
Total	23,455	85,420	27.5%	37,358	62.8%
SA 8					
African American	10,893	15,161	71.8%	6,005	181.4%
Asian/Pacific Islander	2,413	11,131	21.7%	3,318	72.7%
Latino	13,758	41,899	32.8%	19,036	72.3%
Native American	135	281	48.0%	85	158.8%
White	7,526	25,907	29.1%	4,220	178.3%
Total	34,725	94,379	36.8%	32,664	106.3%

TABLE 24 (contd.): PENETRATION RATE FOR SED AND SMI POPULATION FY 10-11

Ethnicity by Service Area (SA)	Number of Consumers Served	Population Estimated with SED & SMI	Penetration Rate for Total Population Estimated with SED & SMI	Population Estimated with SED & SMI AND Living at or Below 200% FPL	Penetration Rates for Population Living at or Below 200% FPL and Estimated with SED & SMI
Countywide (Consumers Served in At Least One Service Area)					
African American	47,859	57,056	83.9%	25,546	187.3%
Asian/Pacific Islander	8,591	66,059	13.0%	22,251	38.6%
Latino	90,127	328,152	27.5%	170,056	53.0%
Native American	924	1,512	61.1%	681	135.7%
White	38,607	163,699	23.6%	35,617	108.4%
Total	186,108	616,477	30.2%	254,151	73.2%
Countywide (Consumers Served in More Than One Service Area)					
African American	11,413	NA	NA	NA	NA
Asian/Pacific Islander	972	NA	NA	NA	NA
Latino	15,573	NA	NA	NA	NA
Native American	176	NA	NA	NA	NA
White	6,167	NA	NA	NA	NA
Total	34,301	NA	NA	NA	NA

Note: Numbers served represent consumers served by LACDMH in Short Doyle/Medi-Cal Facilities. Excludes "Other" (N = 3,367) and "Unknown" (N = 5,026) ethnic groups. Total does not include consumers served in Fee-For-Service Facilities, institutional facilities such as jails, probation camps and Inpatient facilities.

TABLE 25: RETENTION RATE – NUMBER OF APPROVED OUTPATIENT CLAIMS BY ETHNICITY - FY 10-11

Number of Claims	African American	Asian/Pacific Islander	Latino	Native American	Other	White	Total
One							
Consumers	**6,123**	**718**	**9,726**	**80**	**458**	**5,091**	**22,196**
Percent	27.6%	3.2%	43.8%	0.4%	2.1%	22.9%	100%
Two							
Consumers	**3,485**	**452**	**5,654**	**49**	**255**	**3,058**	**12,953**
Percent	26.9%	3.5%	43.7%	0.4%	2.0%	23.6%	100%
Three							
Consumers	**2,850**	**383**	**4,513**	**43**	**227**	**2,388**	**10,404**
Percent	27.4%	3.7%	43.4%	0.4%	2.2%	23.0%	100%
Four							
Consumers	**2,627**	**338**	**4,045**	**50**	**192**	**2,051**	**9,303**
Percent	28.2%	3.6%	43.5%	0.5%	2.1%	22.0%	100%
5-15							
Consumers	**15,376**	**2,933**	**26,282**	**308**	**1,020**	**12,630**	**58,549**
Percent	26.3%	5.0%	44.9%	0.5%	1.7%	21.6%	100%
16 or More							
Consumers	**14,691**	**3,395**	**31,841**	**354**	**980**	**11,680**	**62,941**
Percent	23.3%	5.4%	50.6%	0.6%	1.6%	18.6%	100%
Total							
Consumers	**45,152**	**8,219**	**82,061**	**884**	**3,132**	**36,898**	**176,346**
Percent	25.6%	4.7%	46.5%	0.5%	1.8%	20.9%	100%

Table 25 shows the Retention Rate by Ethnicity for FY 10-11.

TABLE 26: RETENTION RATE-NUMBER OF APPROVED OUTPATIENT CLAIMS - FOUR YEAR TREND FY 07-08 TO FY 10-11

Fiscal Year				
Number of Claims	**FY 07-08**	**FY 08-09**	**FY 09-10**	**FY 10-11**
1				
Consumers	16,602	17,296	17,400	22,196
Percent	11.0%	10.7%	10.3%	12.6%
2				
Consumers	8,447	9,222	9,604	12,953
Percent	5.6%	5.7%	5.7%	7.3%
3				
Consumers	6,949	7,444	8,058	10,404
Percent	4.6%	4.6%	4.8%	5.9%
4				
Consumers	6,429	6,471	7,056	9,303
Percent	4.3%	4.0%	4.2%	5.3%
5-15				
Consumers	46,604	47,872	52,166	58,549
Percent	30.9%	29.7%	30.9%	33.2%
16 or More				
Consumers	65,973	72,901	74,491	62,941
Percent	43.7%	45.2%	44.1%	35.7%
Total				
Consumers	151,004	161,206	168,775	176,346
Percent	100.0%	100.0%	100.0%	100.0%

Table 26 shows a four-year trend for Retention Rate – Number of Approved Outpatient Claims from FY 07-08 to FY 10-11.

FIGURE 53: PENETRATION RATE FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL FY 07-08 TO FY 10-11 - SA 1

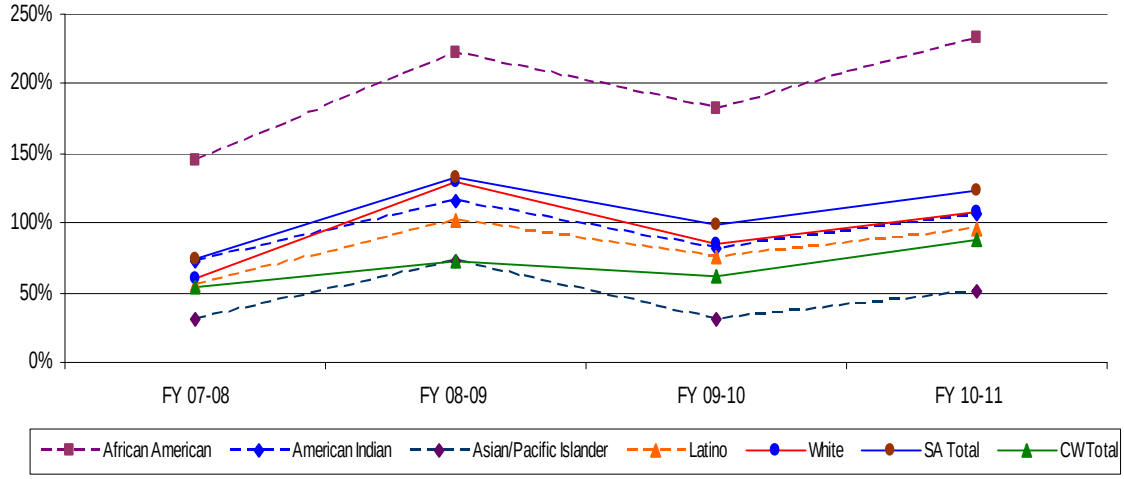


Figure 53 shows a 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 07-08 to FY 10-11 in Service Area 1.

FIGURE 54: RETENTION RATE BY ETHNICITY FY 10-11 - SA 1

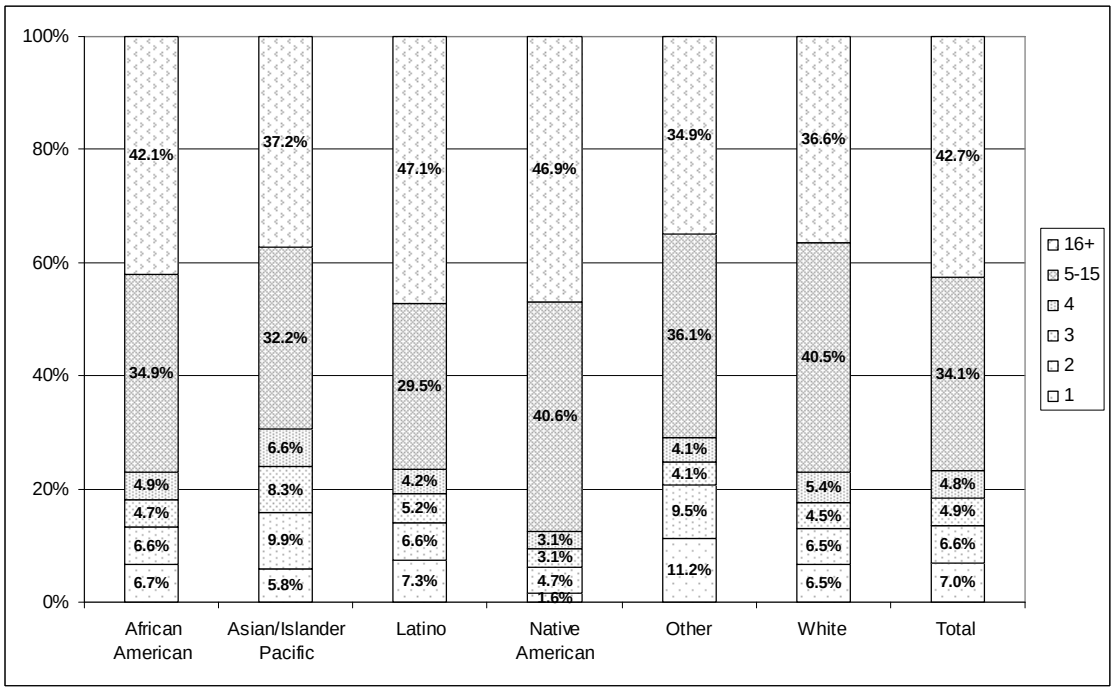


Figure 54 shows the number of approved outpatient claims (Retention Rate) by ethnicity for consumers served in FY 10-11 in Service Area 1.

FIGURE 55: PENETRATION RATE FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL FY 07-08 TO FY 10-11 - SA 2

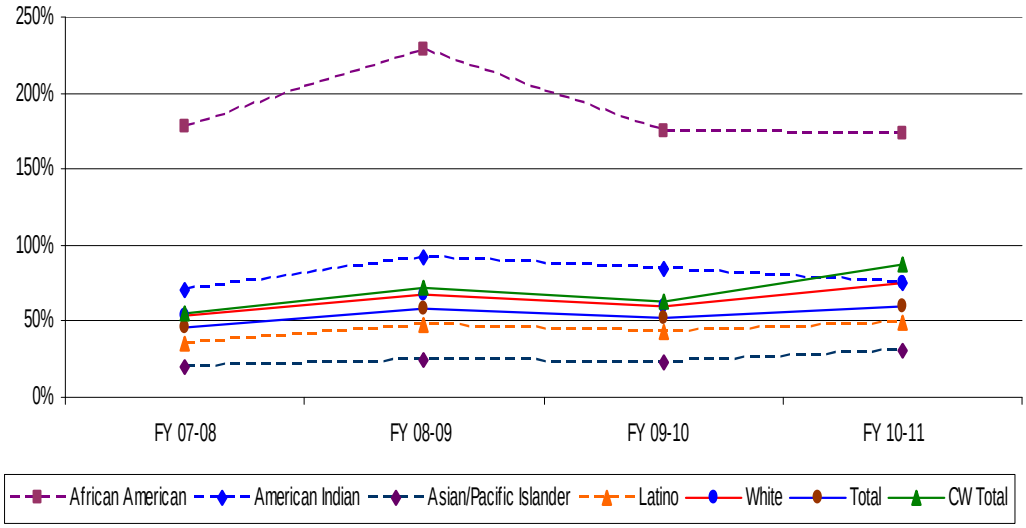


Figure 55 shows a 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 07-08 to FY 10-11 in Service Area 2.

FIGURE 56: RETENTION RATE BY ETHNICITY FY 10-11 - SA 2

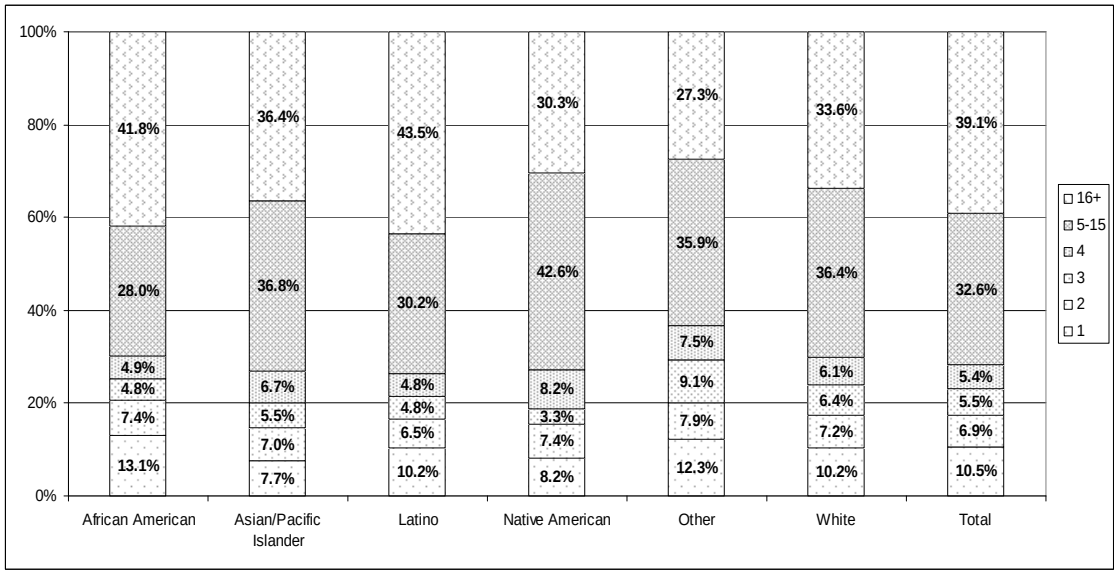


Figure 56 shows the number of approved outpatient claims (Retention Rate) by ethnicity for consumers served in FY 10-11 in Service Area 2.

FIGURE 57: PENETRATION RATE FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL FY 07-08 TO FY 10-11 - SA 3

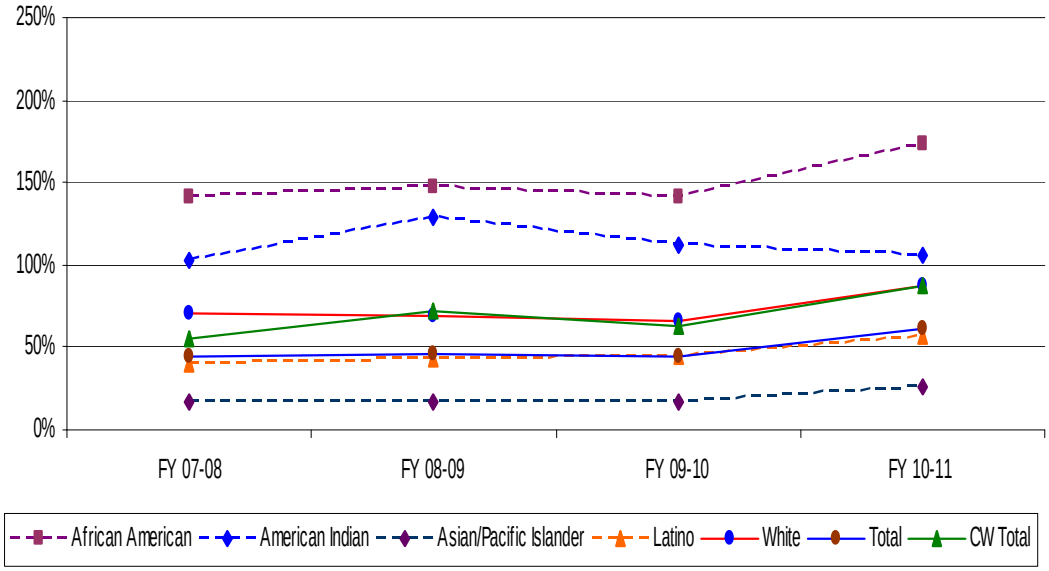


Figure 57 shows a 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 07-08 to FY 10-11 in Service Area 3.

FIGURE 58: RETENTION RATE BY ETHNICITY FY 10-11 - SA 3

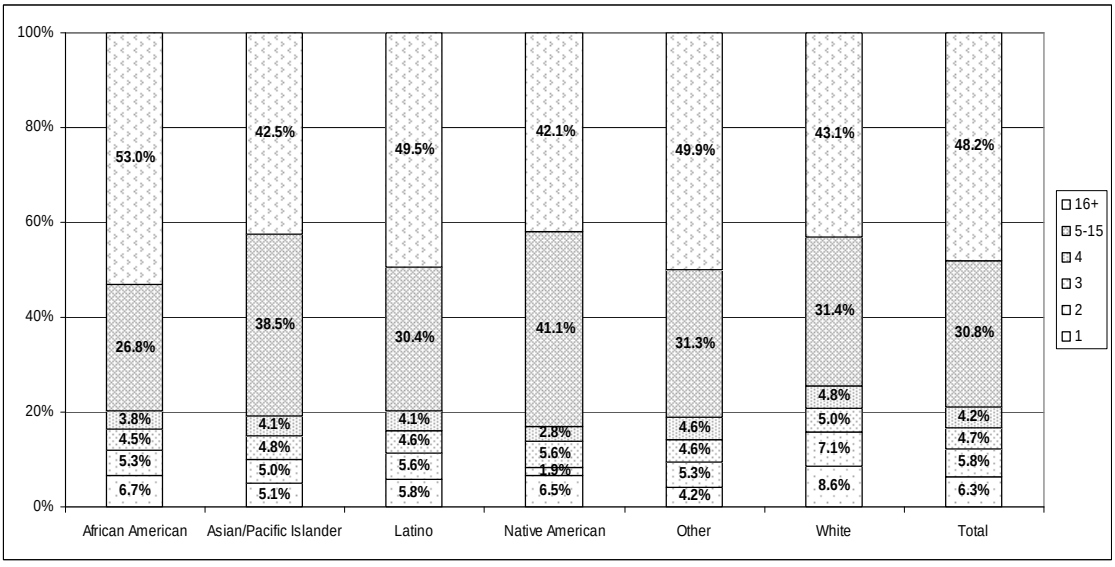


Figure 58 shows the number of approved outpatient claims (Retention Rate) by ethnicity for consumers served in FY 10-11 in Service Area 3.

FIGURE 59: PENETRATION RATE FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL FY 07-08 TO FY 10-11 - SA 4

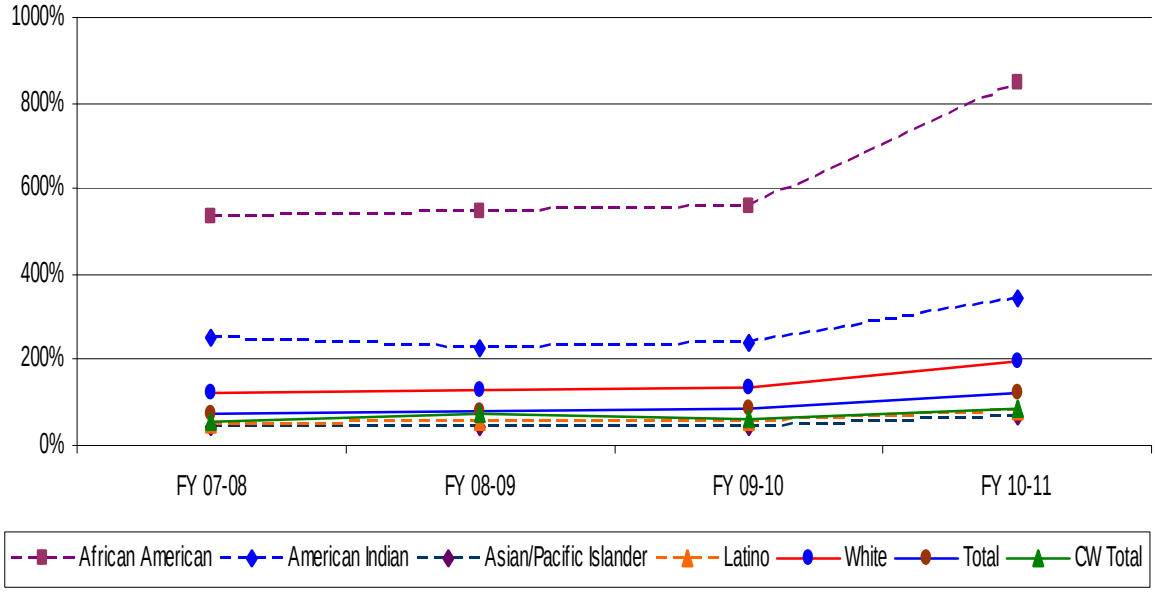


Figure 59 shows a 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 07-08 to FY 10-11 in Service Area 4.

FIGURE 60: RETENTION RATE NUMBER OF APPROVED OUTPATIENT CLAIMS FY 10-11 - SA 4

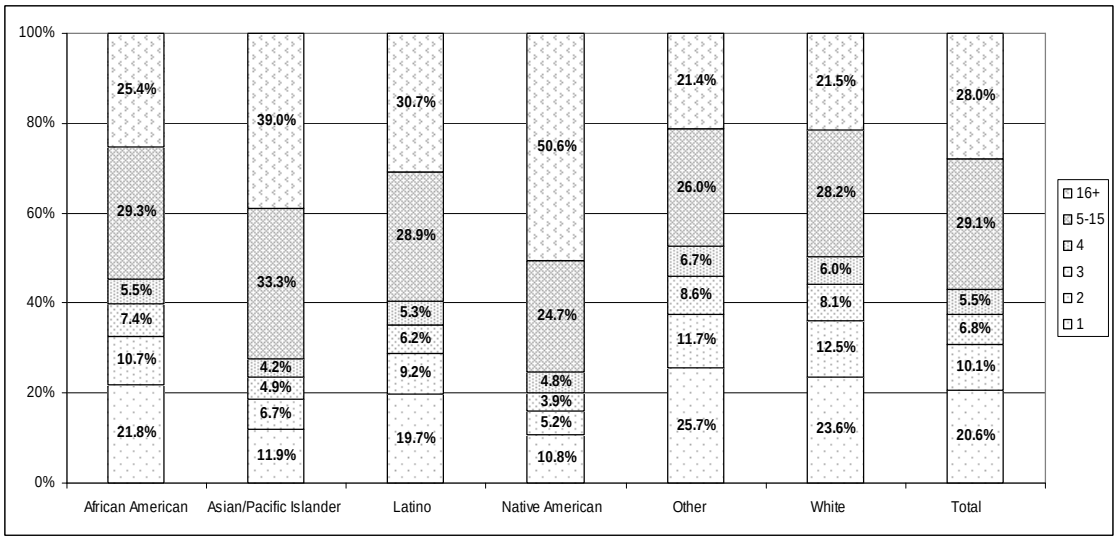


Figure 60 shows the number of approved outpatient claims (Retention Rate) by ethnicity for consumers served in FY 10-11 in Service Area 4.

FIGURE 61: PENETRATION RATE FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL FY 07-08 TO FY 10-11 - SA 5

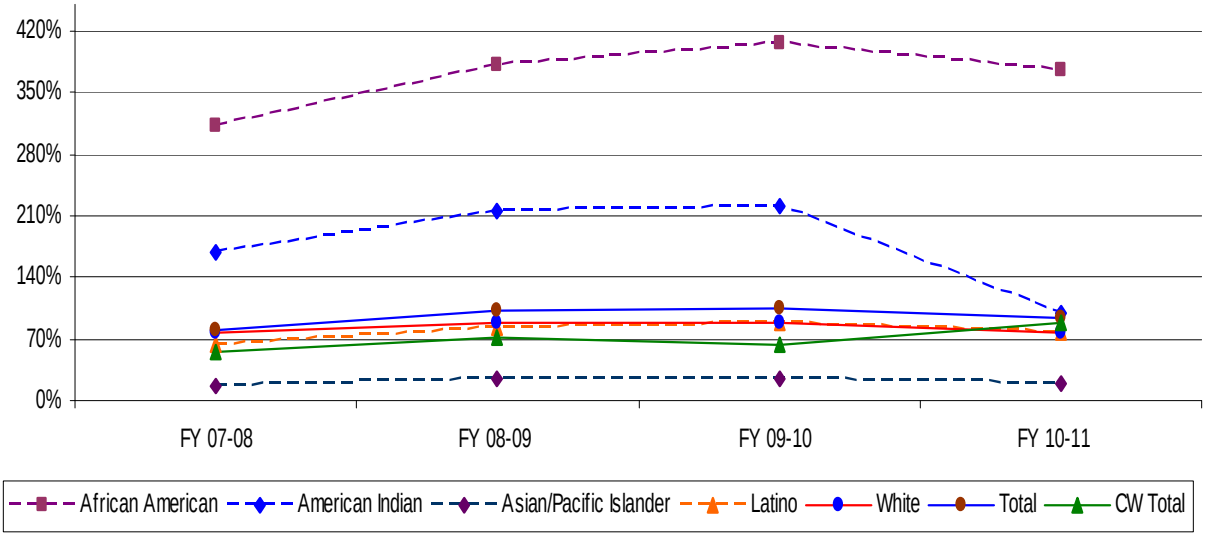


Figure 61 shows a 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 07-08 to FY 10-11 in Service Area 5.

FIGURE 62: RETENTION RATE BY ETHNICITY FY 10-12 - SA 5

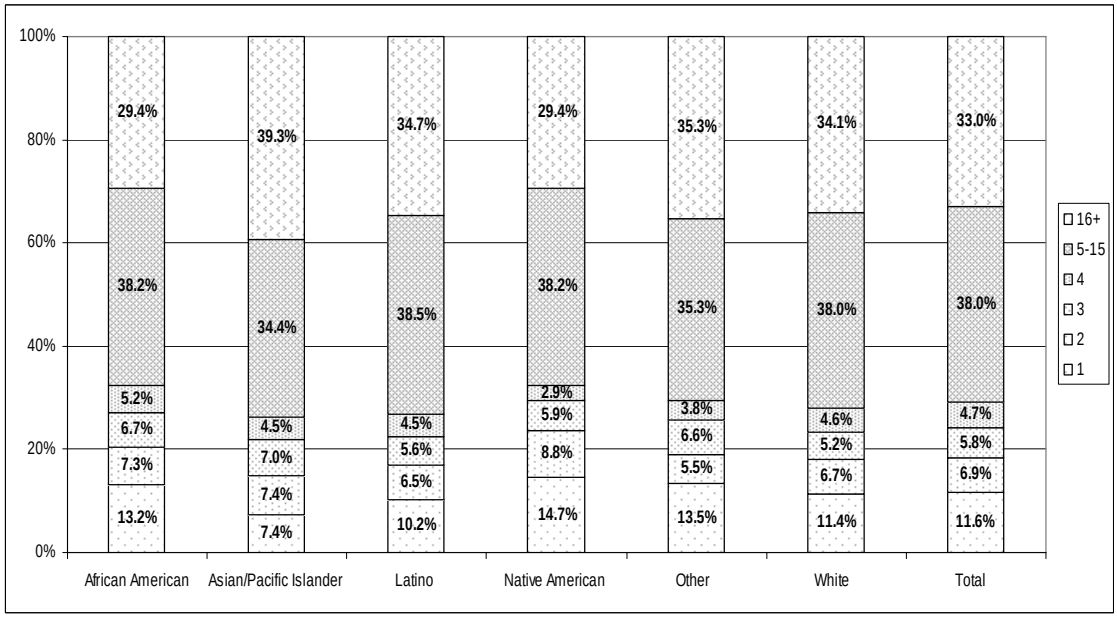


Figure 62 shows the number of approved outpatient claims (Retention Rate) by ethnicity for consumers served in FY 10-11 in Service Area 5.

FIGURE 63: PENETRATION RATE FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL FY 07-08 TO FY 10-11 - SA 6

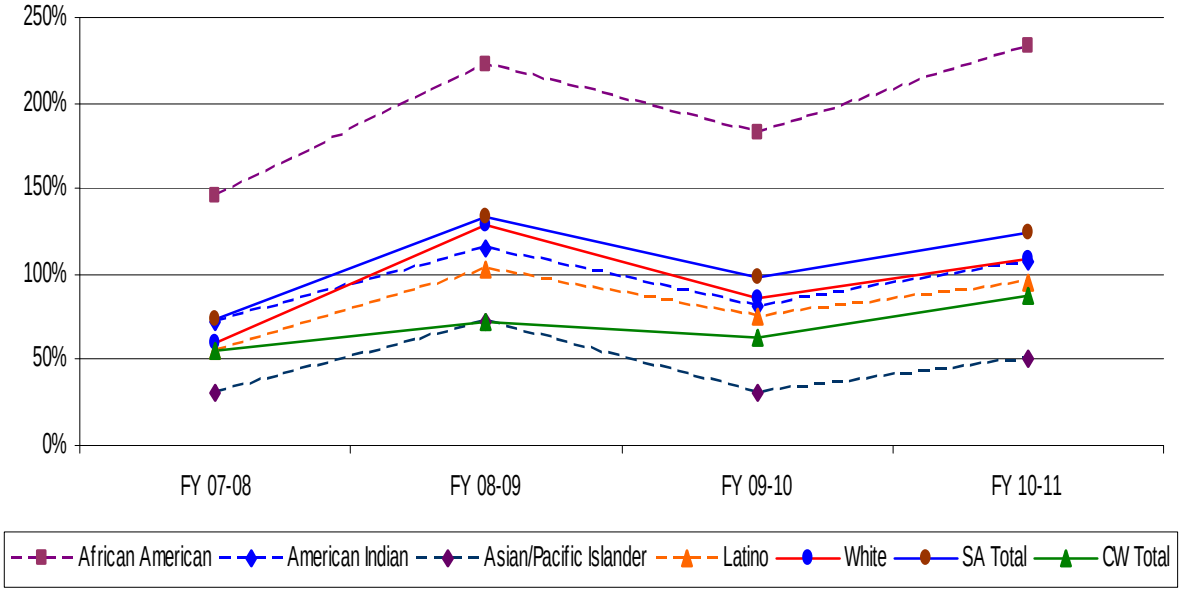


Figure 63 shows a 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 07-08 to FY 10-11 in Service Area 6.

FIGURE 64: RETENTION RATE BY ETHNICITY FY 10-11 - SA 6

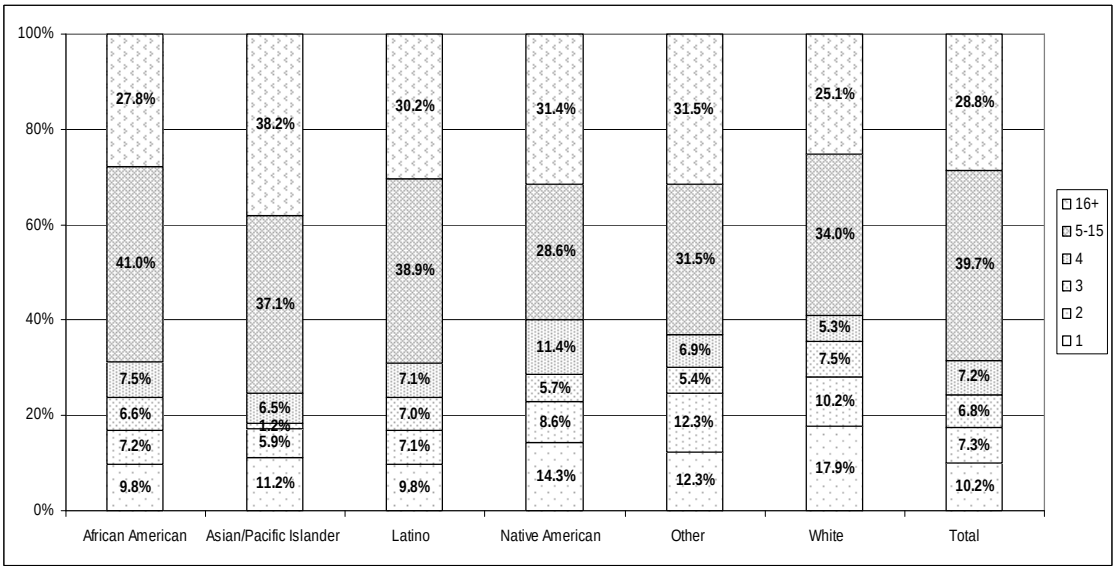


Figure 64 shows the number of approved outpatient claims (Retention Rate) by ethnicity for consumers served in FY 10-11 in Service Area 6.

FIGURE 65: PENETRATION RATE FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL FY 07-08 TO FY 10-11 - SA 7

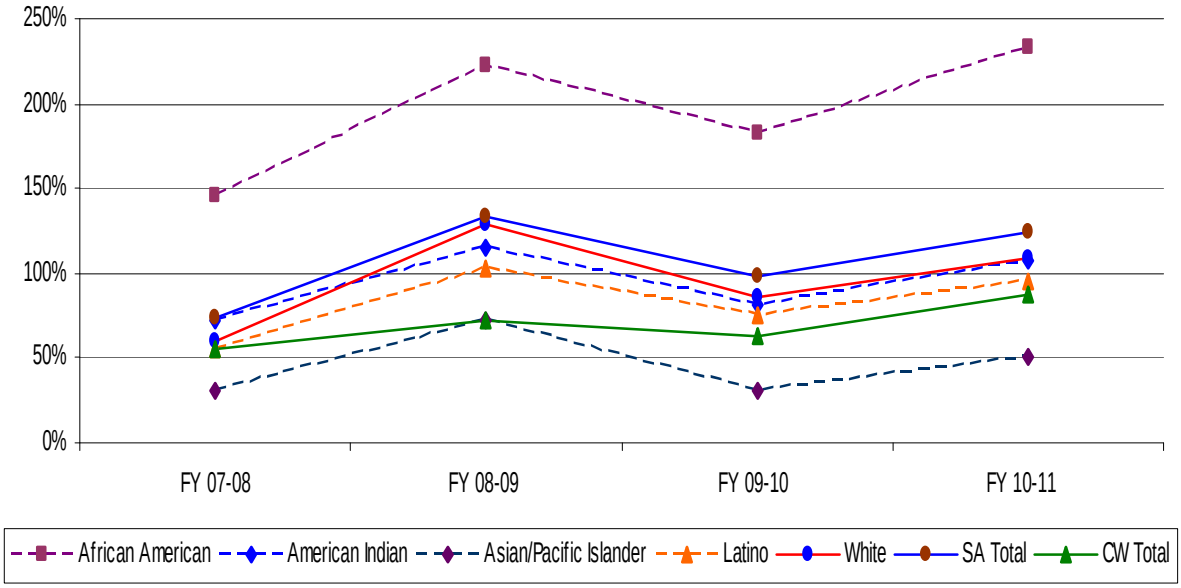


Figure 65 shows a 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 07-08 to FY 10-11 in Service Area 7.

FIGURE 66: RETENTION RATE BY ETHNICITY FY 10-11 - SA 7

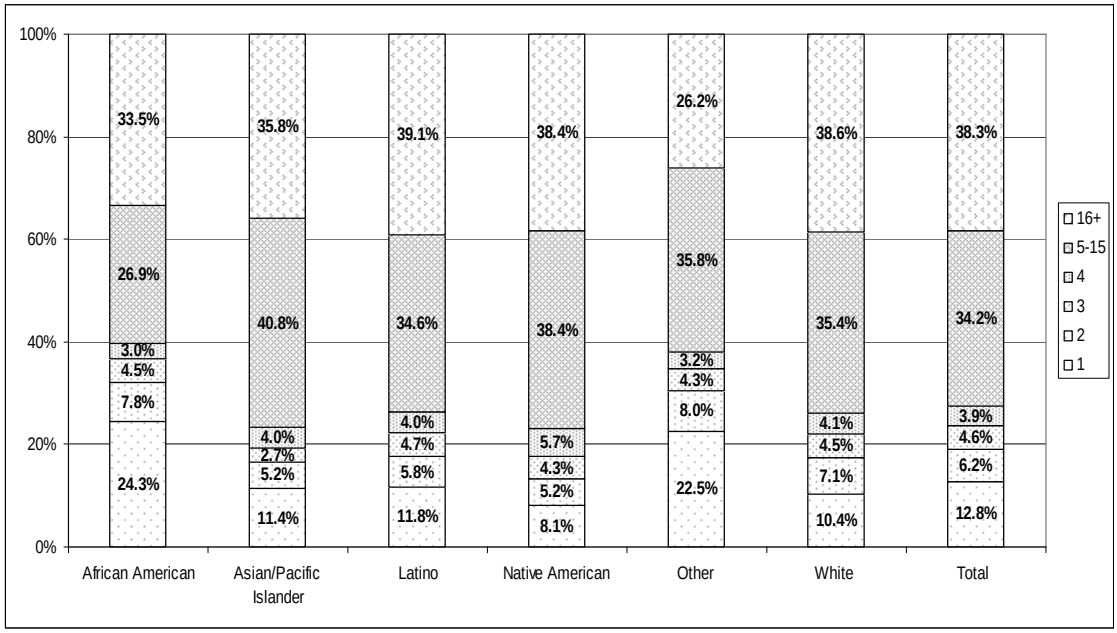


Figure 66 shows number of approved outpatient claims (Retention Rate) by ethnicity for consumers served in FY 10-11 in Service Area 7.

FIGURE 67: PENETRATION RATE FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL FY 07-08 TO FY 10-11 - SA 8

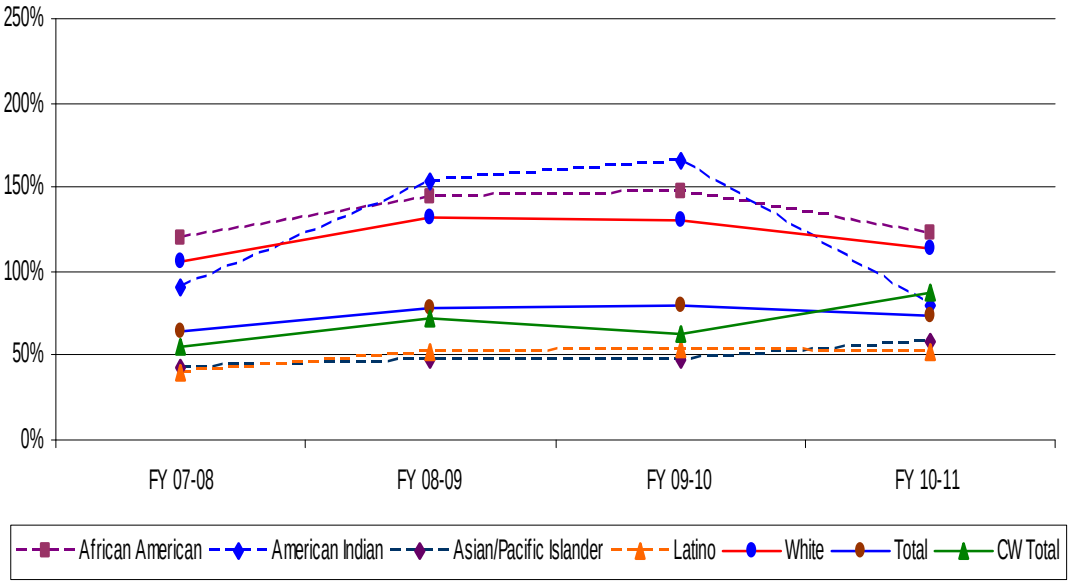


Figure 67 shows a 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 07-08 to FY 10-11 in Service Area 8.

FIGURE 68: RETENTION RATE BY ETHNICITY FY 10-11 - SA 8

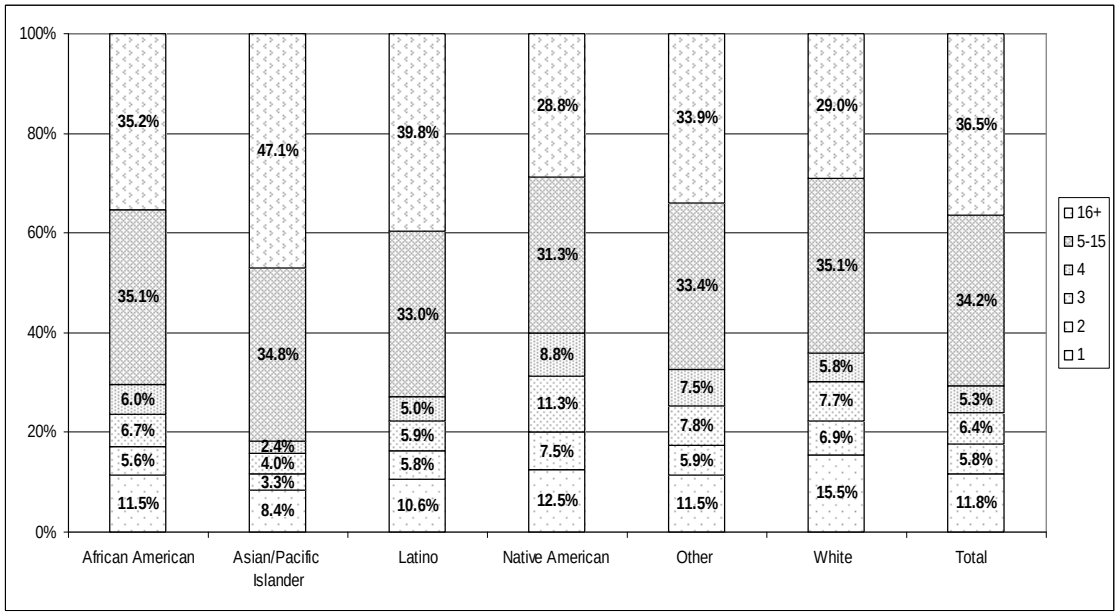


Figure 68 shows the number of approved outpatient claims (Retention Rate) by ethnicity for consumers served in FY 10-11 in Service Area 8.

FIGURE 69: PENETRATION RATE FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL FY 07-08 TO FY 10-11 - COUNTYWIDE

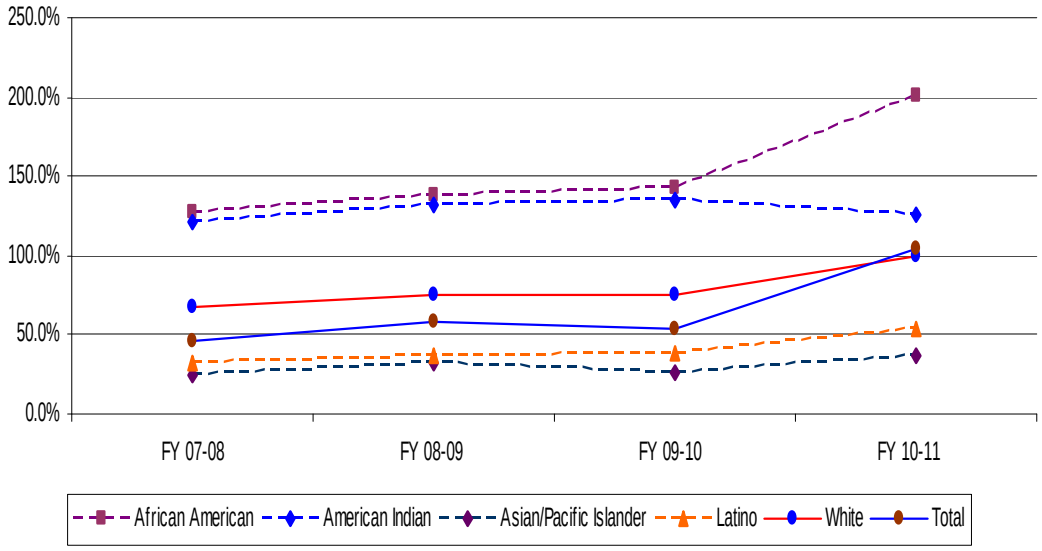


Figure 69 shows a Countywide 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 07-08 to FY 10-11.

FIGURE 70: RETENTION RATE BY ETHNICITY FY 10-11 - COUNTYWIDE

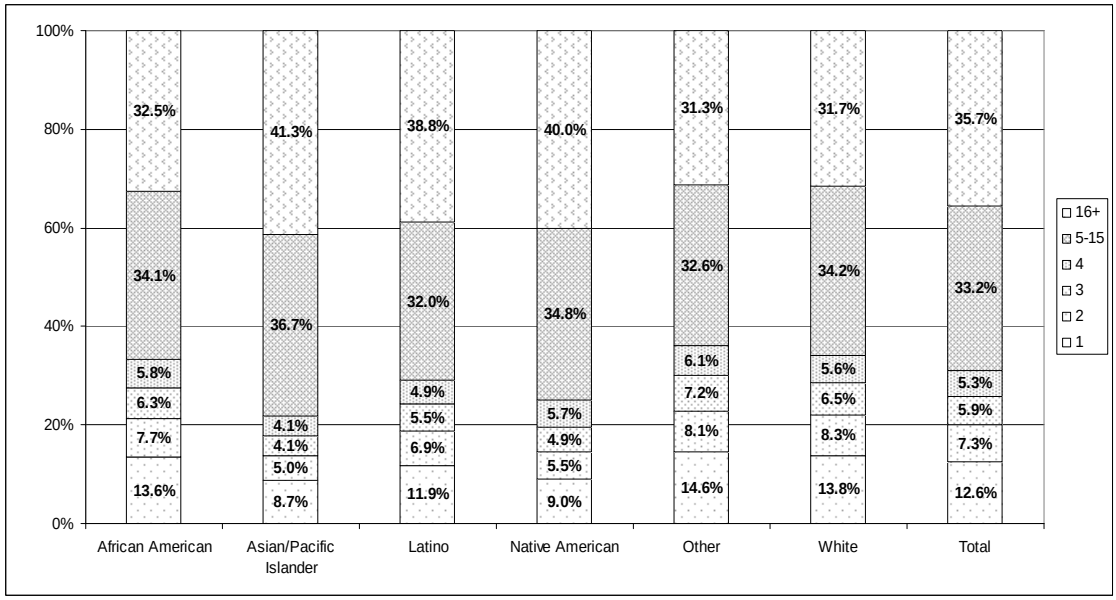


Figure 70 shows Countywide number of approved outpatient claims (Retention Rate) by ethnicity for consumers served in FY 10-11.

Goal I. 2.
The Cultural Competency Unit, the Cultural Competency Committee, the Quality Improvement Council, and the Service Area Quality Improvement Committees will collaboratively identify and select strategies and interventions to improve the API Penetration Rate (for the population at or below 200% poverty) which has decreased by 3.2% between 2007 and 2010.

As noted above, the Penetration rate goals for the API and Latino populations have been met and exceeded for FY10-11. The Cultural Competency Unit, through ongoing collaboration with the Cultural Competency Committee (CCC) continues to promote and implement strategies to improve the ability of ethnic groups to access needed mental health services. The membership of the CCC is comprised of Stakeholders from throughout the Service Areas, representing Consumers, Family Member/Caregivers, Community Members, DMH Staff, and DMH Contract Agency Staff. Within the current CCC membership, there are eight ethnic groups and eleven languages represented. The Cultural Competency Unit participates at Monthly Departmental QIC Meetings, a forum in which Cultural Competency goals are shared with Service Area QIC liaisons and representatives, and feedback is gathered. Through the systemic interactions between the Cultural Competency Committee, the Cultural Competency Unit, and the Departmental Quality Improvement Council, the LACDMH moves toward meeting its commitment to address disparities in mental health services for its consumers.

II. MONITORING ACCESSIBILITY OF SERVICES

ACCESS Center PMRT Response Time

Goal II. 1.
Maintain access to after-hour care at 69% of PMRT response time of one hour between PMRT acknowledgement of the call to PMRT arrival on the scene and continue year to year trending.

Numerator: PMRT responses within one hour (after hours)

Denominator: Total number of PMRT responses (after hours)

EVALUATION

This goal has been met.

As shown in Table 25, data collected between January and December of 2011 indicate that an average of 70% of PMRT calls resulted in mobile teams being present at the scene within one hour of acknowledged receipt of the call. This reflects a 1% improvement over the previous year performance of 69% which was achieved in 2010.

Compared to 2010, in 2011 there were 431 or 11% more After-Hour PMRT responses. The number of responses within 1 hour improved during an increase in response volume. The highest response rate within one hour at 76% occurred in January 2011. The lowest response rate within one hour at 66% occurred in November 2011.

Although higher response rates were achieved during 2007 and 2008, at that time there were 9 psychiatric mobile response teams providing coverage as compared to 5 teams beginning in 2009. The 5% drop in PMRT after hour response time occurring in 2010 as compared to 2007 is largely due to the reduced availability of after-hour PMRT capacity. Between 2009 and 2011 there has been a 1% improvement each year. This improvement occurred during an increase of 840 or 25% more calls from 3,448 in 2009 to 4,288 in 2011.

The LACDMH utilizes the ACCESS Center responsiveness of PMRT as an indicator to monitor psychiatric mobile team response times to field visits requiring their rapid intervention and assistance. The rationale for this indicator is the significance of providing alternatives to hospitalization and linkage with other alternatives to hospitalization, such as Urgent Care Centers. Additionally, the response time to urgent field visits is measured in four incremental response time categories, beginning with 45 minutes or less and ending with 91 minutes or more. The Performance Counts! Report provides detailed data for this indicator.

The PMRT measure reported is specific to responses made after-hours. It is important to note that the Performance Counts! Measure uses the Fiscal Year time period, whereas the PMRT measure reported here uses a Calendar Year time period. The response time for all calls within one hour was 76% in 2011.

TABLE 27: PMRT[1] AFTER-HOUR RESPONSE RATES OF ONE HOUR OR LESS - CY 2007-2011

	2007	2008	2009	2010	2011
January	76%	78%	68%	67%	76%
February	71%	75%	69%	65%	72%
March	72%	74%	64%	63%	71%
April	74%	76%	68%	65%	69%
May	75%	71%	72%	63%	74%
June	75%	71%	72%	68%	68%
July	71%	71%	72%	71%	71%
August	75%	73%	62%	75%	67%
September	72%	72%	63%	74%	68%
October	71%	71%	69%	71%	68%
November	77%	70%	66%	70%	66%
December	73%	72%	66%	71%	68%
Annual Total	**5,855**	**3,357**	**3,448**	**3,857**	**4,288**
Annual Average %	**74%**	**73%**	**68%**	**69%**	**70%**

[1] Psychiatric Mobile Response Team

Table 27 shows the rate of PMRT after-hour responses that are within one hour.

ACCESS Center Abandoned Call Rate

Goal II. 2.

Maintain the rate of abandoned calls (responsiveness of the 24-hour toll free number) at an overall annual rate of 15%.

Numerator: Total number of calls in which caller hung up after 30 seconds.

Denominator: Total number of calls completed to the ACCESS Center.

EVALUATION

This goal has been met.

The LACDMH utilizes the ACCESS Center Abandoned Call Rates as an indicator of response time to calls received by the 24/7 Toll-Free Telephone Line for mental health services and other referrals as appropriate, including the calls received in non-English languages. This national indicator is also monitored by LACDMH Test-Calls Protocols and data is reported in the Annual Test-Calls Report (Please see Tables 26 and 27).

Table 26 shows higher abandoned call rates at 19% during the months of January through March 2011. The average abandoned call rate for April through December was 14%. The average number of calls per month from January to March 2011 was 25,996, whereas the average number of calls per month from April to December was 25,164. There was an average of 834 or 3% more monthly calls in the months of January to March than April to December 2011.

October had a higher call volume in 2010 and 2011 with 28,288 and 28,692, respectively. The abandoned call rate in October 2010 was the highest rate of the year at 19%, whereas the abandoned call rate in October 2011 was an average rate of the year at 15%. This reduction in the Abandoned Call Rate in October 2011 occurred during a period of high volume.

In 2011, there were 9,454 or 3% more calls placed to the ACCESS Center compared to 2010. The ACCESS Center maintained an Abandoned Call rate at 15% during an increase in call volume. The ACCESS Center is currently upgrading and improving its phone system which is expected to yield further improvement in the effective and timely processing of calls.

TABLE 28: ABANDONED CALLS BY NUMBER AND PERCENT - CY 2011

Month	Total Calls	Number Abandoned	Percent Abandoned
January	26,498	4,971	19%
February	24,521	4,655	19%
March	26,968	5,083	19%
April	24,517	3,992	16%
May	25,969	4,226	16%
June	24,096	3,195	13%
July	23,696	3,194	13%
August	24,980	2,934	12%
September	25,465	3,185	13%
October	28,892	4,426	15%
November	25,855	3,577	14%
December	23,013	2,711	12%
Total	**304,470**	**46,149**	**15%**

Table 28 shows the number and percent of abandoned calls to the ACCESS Center in CY 2011.

TABLE 29: ABANDONED CALL RATE FOUR-YEAR TREND - CY 2008-2011

Calendar Year	2008	2009	2010	2011
Total Calls	275,051	283,098	295,016	304,470
Number Abandoned	35,401	40,107	44,499	46,149
Percent	13%	14%	15%	15%

Table 29 shows the rate of abandoned calls from CY 2008 to CY 2011.

ACCESS Center Language of Calls Received

Table 28 shows Spanish as the second most common language after English for calls received by the ACCESS Center in 2011, at 8,675 calls or 96.5% of all non-English calls. The third most common language of calls received by the ACCESS Center in 2011 are in Chinese (Mandarin and Cantonese) at 71 calls or 1.0% of all non-English calls.

The number of non-English calls from 2008 to 2011 increased 60% from 5,650 to 8,990 calls. This increase is largely due to the increase in the number of Spanish calls to the ACCESS Center, which increased 63% from 5,325 in 2008 to 8,675 in 2011.

The number of non-English calls decreased 6% from 2010 to 2011 from 9,523 calls to 8,990 (-533) calls. This decrease can be largely accounted for by the decrease of Spanish calls from 2010 to 2011 which decreased 6% from 9,191 calls to 8,675 (-518) calls. The total number of calls to the ACCESS Center actually increased 3% from 2010 to 2011 from 295,016 calls to 304,470 (+9,454) calls.

TABLE 30: LANGUAGE OF CALLS RECEIVED OTHER THAN ENGLISH CY 2008-2011

Language	2008	2009	2010	2011	Total
AMHARIC	0	4	0	2	6
ARABIC	8	5	13	7	33
ARMENIAN	28	34	36	35	133
BENGALI	0	0	3	1	4
BULGARIAN	0	0	1	0	1
BURMESE	0	1	3	0	4
CAMBODIAN	5	6	5	0	16
CANTONESE	31	48	19	19	117
FARSI	21	21	31	46	98
FRENCH	0	0	1	2	3
GERMAN	0	0	2	0	2
HEBREW	0	1	0	0	1
HINDI	0	5	0	1	6
HUNGARIAN	0	0	0	0	0
ITALIAN	1	1	1	0	3
JAPANESE	8	6	7	6	27
KHMER	0	0	5	16	21
KOREAN	86	79	61	54	280
LAOTIAN	1	0	0	0	1
MANDARIN	34	39	59	52	184
OROMO	0	2	0	0	2
POLISH	5	3	0	0	8
PORTUGUESE	2	1	1	0	4
PUNJABI	0	4	2	0	6
SERBIAN	0	0	5	0	5
ROMANIAN	4	0	1	0	5
RUSSIAN	14	8	15	21	58
SERBIAN	0	0	5	0	5
SPANISH	2,441	4,940	4,547	4,282	16,210
SPANISH ACCESS CTR	2,884	4,055	4,644	4,393	15,976
SPANISH SUB TOTAL	5,325	8,995	9,191	8,675	32,186
TAGALOG	74	35	26	35	170
THAI	2	0	6	2	10
TURKISH	0	2	0	0	2
URDU	1	1	1	1	4
VIETNAMESE	21	31	23	15	90
TOTAL	5,650	9,332	9,523	8,990	33,495

Table 30 shows the number of calls in different languages to the ACCESS Center from CY 2008 to CY 2011.

Consumer Satisfaction Survey Goals

Goal II. 3.
Increase the overall rate by 1% from 88.7% in CY 2010 to 89.7% in CY 2011 for consumers/families reporting that they are able to receive services at convenient locations and continue year-to-year trending.

Please see in Section III "Consumer Satisfaction Survey Goals" for an outline of how the Consumer Satisfaction data will be collected for the FY 11-12 Survey period.

Goal II. 4.
Increase the overall rate by 1% from 90.7% in CY 2010 to 91.7% in CY 2011 for consumer/families reporting that they are able to receive services at convenient times and continue year to year trending.

Please see in Section III "Consumer Satisfaction Survey Goals" for an outline of how the Consumer Satisfaction data will be collected for the FY 11-12 Survey period.

III. MONITORING BENEFICIARY SATISFACTION

Goal III. 1.
Participate with CDMH new survey methodology (once a year) for the Statewide Performance Outcomes, determine improved survey sampling methodology, and continue year to year trending.

At this time, data for the FY 11-12 Consumer Satisfaction Surveys is presently being compiled. For this survey period, LACDMH has partnered with UCLA-Integrated Substance Abuse Programs (ISAP) to pilot an abbreviated version of the MHSIP surveys. The goal of this initiative is to allow LACDMH to transition to a new and meaningful data collection methodology that ensures the following: 1. Randomized representative sampling; 2. Cost-effective user friendly short forms; 3. Trend analysis of satisfaction domains, and 4. Enhanced statistical analysis and scientific rigor for internal annual performance monitoring.

The abbreviated survey will consist of 3 survey forms, the Family Survey (0 to 17 years of age), the Youth Survey (13 to 17 years of Age) and the Adult Survey (18 years and above), each has 7 survey questions. A total of 10 items from the MHSIP survey are used for the seven questions on each of the 3 abbreviated survey forms that have been developed. These 10 items were adopted from the 64 item MHSIP surveys via an inter-disciplinary Stakeholder process carried out in 2007 (please refer to State Performance Outcomes and County Performance Outcomes Report CY 2008 for more information). Initial data using these abbreviated surveys was collected in 2008 in field settings as well as Outpatient Clinics and Day Treatment programs.

The FY 11-12 Consumer Satisfaction Survey data collection survey period took place from February 13, 2012, to February 27, 2012. All Directly Operated and

Contracted Outpatient Mental Health Clinics, in addition to DMH Outpatient Fee-For-Service (FFS) Individual Providers administered the Consumer Satisfaction Surveys.

LACDMH has previously participated annually, each May and November, in the State Performance Outcomes and Federal Block Grant for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), consumer and family perception of satisfaction survey administration. In 2008, the LACDMH began collecting MHSIP survey data to provide a baseline performance standard that could be used to gage data obtained in future years. In 2009, follow up data was collected and comparative analysis with baseline standards was carried out. This data is presented in the 2010 QI Work Plan Evaluation Report.

In 2010 the Mental Health Plan Directors of California were sent the following California Department of Mental Health memo dated June 14, 2010:

"In recognition of the economic pressures placed upon state and local governments, the May DMH consumer perception survey county data collection requirement will be suspended for this year to help relieve administrative burden on counties. However, in order to fulfill SAMHSA Block Grant requirements to collect this data, DMH will collaborate with the Institute for Social Research (ISR) in developing and pilot testing a random sampling approach for Fiscal year 2009-2010."

The State DMH implemented this MHSIP pilot in July 2010. In November 7, 2011, in DMH Information Notice No. 11-14, the State DMH informed the County Mental Health Plans that the California Institute for Mental Health (CiMH) was contracted to scan and process submitted survey forms and aggregate data collected by the counties. Counties were asked to organize and implement their own Consumer Satisfaction Survey data collection, and submit their data to CiMH. LACDMH initiated the pilot survey in collaboration with the UCLA-ISAP in October 2011.

Statistical Analysis of Abbreviated Surveys

Of the seven (7) domains measured in the MHSIP YSS-F and YSS Surveys, five domains (General Satisfaction, Perception of Access, Perception of Cultural Sensitivity, Perception of Outcomes of Services and Perception of Social Connectedness) are represented in the LACDMH Outcome Measures abbreviated survey.

The General Satisfaction domain is represented by one item "I felt I/My child had someone to talk to when he/she was troubled." The Perception of Access domain consists of two items "The location of services was convenient for me/us", and "Services were available at times that were convenient for me/us." Both of these items are represented in the abbreviated survey and are not tested for reliability. The Perception of Cultural Sensitivity is presented by one item, "Staff were sensitive to my cultural/ethnic background." The Perception of Outcomes of

Services is represented by two items “I/My Child gets along better with family members” and “I/My Child is doing better in school and/or work.” The Perception of Social Connectedness is represented by one item “In a crisis, I would have the support I need from family or friends.”

The remaining two domains, Perception of Participation in Treatment Planning and Perception of Functioning are not represented in the abbreviated survey.

The following table shows statistical reliability of the individual abbreviated survey and factor loadings with the perception domains measured as a factor or a scale in the MHSIP survey.

TABLE 31A: FACTOR LOADINGS OF ABBREVIATED SURVEY ITEMS YSS-F and YSS

Perception of General Satisfaction		
	YSS-F (N 4,335)	**YSS (N = 2,762)**
Cronbach's Alpha for 6 item MHSIP scale	.91	.90
Factor Loading[1]		
I felt I/My child had someone to talk to when he/she was troubled.	.83	.81
Perception of Cultural Sensitivity		
	YSS-F (N 4,151)	**YSS (N = 2,500)**
Cronbach's Alpha for 4 item MHSIP scale	.94	.89
Factor Loading[1]		
Staff were sensitive to my cultural ethnic background	.91	.83
Perception of Outcomes of Services		
	YSS-F (N 4,324)	**YSS (N = 2,720)**
Cronbach's Alpha	.92	.86
Factor Loading[1]		
I/My Child gets along better with family members	.88	.75
I/My Child is doing better in school and/or work.	.81	.74
Perception of Social Connectedness		
	YSS-F (N 4,885)	**YSS (N = 2,835)**
Cronbach's Alpha	.87	.86
Factor Loading[1]		
In a crisis, I would have the support I need from family or friends.	.83	.81

[1] Factor loading of County Outcome Measure in the abbreviated survey with MHSIP Perception Domains

Table 31A shows that all of the perception domains in the MHSIP survey have a high reliability of .86 or higher. A Cronbach's alpha of .70 or higher represents a reliable scale. The factor loadings of individual abbreviated survey items have a high factor loading of .74 or higher with the perception domain measured in the MHSIP survey. The high factor loadings imply that the domains measured in the MHSIP survey are well measured in the abbreviated survey.

Of the seven (7) domains measured in the MHSIP Adult and Older Adult Surveys, four domains (Perception of Access, Perception of Quality and Appropriateness, Perception of Outcomes of Services and Perception of Functioning) are represented in the LACDMH Outcome Measures abbreviated survey.

The Perception of Access domain is represented by three items “The location of services was convenient”, “Staff were willing to see me as often as I felt it was necessary, and “Services were available at times that were me.” The Perception of Quality and Appropriateness is represented by one item “Staff were sensitive to my cultural/ethnic background.” The Perception of Outcomes of Services is represented by two items “I deal more effectively with my daily problems” and “I do better in school and/or work”. Perception of Functioning is represented by one item “My symptoms are not bothering me as much”.

The remaining three domains, General Satisfaction, Perception of Participation in Treatment Planning and Perception of Social Connectedness are not represented in the abbreviated survey.

The following table shows statistical reliability of the individual abbreviated survey and factor loadings with the perception domains measured as a factor or a scale in the MHSIP survey.

TABLE 31B: FACTOR LOADINGS OF ABBREVIATED SURVEY ITEMS ADULTS AND OLDER ADULTS

Perception of Access		
	Adult (N 4,486)	**Older Adult (N = 319)**
Cronbach’s Alpha for 6 item MHSIP scale	.88	.89
Factor Loading[1]		
The location of services was convenient.	.65	.69
Staffs were willing to see me as often as necessary.	.83	.86
Services were available at times that were good for me.	.84	.86
Perception of Quality and Appropriateness		
	Adult (N = 4,121)	**Older Adult (N =253)**
Cronbach’s Alpha for 4 item MHSIP scale	.93	.94
Factor Loading[1]		
Staff were sensitive to my cultural and ethnic background.	.78	.77

[1] Factor loading of County Outcome Measure in the abbreviated survey with MHSIP Perception Domains

TABLE 31B: FACTOR LOADINGS OF ABBREVIATED SURVEY ITEMS ADULTS AND OLDER ADULTS

Perception of Outcomes of Services		
	Adult (N = 3,441)	**Older Adult (N = 211)**
Cronbach's Alpha for 4 item MHSIP scale	.91	.93
Factor Loading[1] (2 items)		
I deal more effectively with my daily problems.	.76	.84
I do better in school and/or work.	.82	.79
Perception of Functioning		
Adult (N 4,151)	**Adult (N = 4,513)**	**YSS (N = 323)**
Cronbach's Alpha for 4 item MHSIP scale	.91	.94
Factor Loading[1] (1 item)		
My symptoms are not bothering me as much.	.74	.75

[1] Factor loading of County Outcome Measure in the abbreviated survey with MHSIP Perception Domains

Table 31B shows that all the perception domains in the MHSIP survey have a high reliability of .78 or higher. A Cronbach's alpha of .70 or higher represents a reliable scale. The factor loadings of individual abbreviated survey items have a high factor loading of .74 or higher with the perception domain measured in the MHSIP survey. The high factor loadings imply that the domains measured in the MHSIP survey are well measured in the abbreviated survey.

Goal III. 2.
Increase by 1% from 90% in CY 2010 to 91% in CY 2011 consumers/families reporting that staff were sensitive to cultural/ethnic background

Please see in Section III "Consumer Satisfaction Survey Goals" for an outline of how the Consumer Satisfaction data will be collected for the FY 11-12Survey period.

Goal III. 3.
Increase by 1% from 84.4% in CY 2010 to 85.4% in CY 2011 the Overall Satisfaction Percentage Score and initiate year to year trending.

Please see in Section III "Consumer Satisfaction Survey Goals" for an outline of how the Consumer Satisfaction data will be collected for the FY 11-12 Survey period.

Goal III. 4.
Maintain a rate of 94% of consumers/families reporting that written materials are available in their preferred language and continue year to year trending.

Please see in Section III "Consumer Satisfaction Survey Goals" for an outline of how the Consumer Satisfaction data will be collected for the FY 11-12 Survey period.

Goal III. 5.
Continue to identify areas for improvement for Service Area QICs for use in quality improvement activities, and increase Service Area Improvement Projects from 2 to 4.

EVALUATION

This goal has been met.

All Service Areas have participated in the ongoing Countywide Re-Hospitalization Cohort 2 (RC2) PIP as well as the non-clinical EPSDT PIP which was completed in June 2011. All Service Areas are participating in interventions to improve Post Hospitalization Outpatient Access (PHOA) to meet the LACDMH 7-day standard. Service Area Navigators and Service Area Hospital Liaisons are actively engaged in activities that have resulted in improved outcomes for this indicator (Please see RC2 Roadmap).

Service Area 8 Quality Improvement Committee (QIC) members are pursuing a consumer driven project to increase access to information for consumers in SA 8. The idea is to provide information to consumers via informational kiosks to be located within mental health service location lobbies. The QIC has decided to make this a pilot project and to install the informational kiosks at the Long Beach Mental Health Center Adult Clinic in Long Beach and Children's Institute, Inc.

(CII) at the Burton Green Office on Normandie in Torrance first and then to evaluate their efforts before proceeding further. Information that is currently being considered for inclusion in the kiosk project includes information about local food banks, transportation resources, shelter and housing, as well as information about where to find clothing.

From April 6 to May 19, 2011, SA 7 conducted a survey to investigate the client flow in the system of care in SA 7 LACDMH directly operated and contracted mental health clinics. Twenty six surveys were completed by representatives of 4 directly operated programs and 22 contracted agencies. Survey results reveal that all programs work to provide an initial screening immediately so that appropriate referral and service can be provided. Surveyed agencies report varied timeliness goals, for example: priority clients seen immediately, urgent within 5-7 days and routine referrals within 30 calendar days with the goal of 15 days. All programs report ongoing reassessment varying from weekly evaluation to annual reassessment. Agencies report working to ensure clients are referred for higher or lower levels of care as and when appropriate. Most agencies (70.8% or 17 of 26 surveyed) indicated that the SA 7 Navigation Team has assisted with access to appropriate levels of care.

Service Area 2 Administration and Quality Improvement Committee members implemented Consumer Satisfaction methodology to improve and increase survey response rates and accuracy. This methodology included using reminders such as letters, posters, and announcements; offering incentives and prizes to participating clients; offering incentives and prizes to the program or employer that is able to elicit the highest survey response rates; reminding and ensuring consumers that their responses are anonymous and confidential; creating a survey sticker for participating staff that help with the survey process and for consumers that complete the surveys and the development of a helpful tips list.

LACDMH is participating in collaboration with seven participating counties in a statewide initiative coordinated by CiMH, the Care Integration Collaborative. The goal of this Collaborative is to improve the quality and integration of care for persons with serious and co-occurring mental health, physical health, and/or substance abuse disorders. For the duration of this collaboration, the rapid cycle improvement strategies of Plan, Do, Study, and Act (PDSA) will be implemented in designated Service Areas. It is also expected that these Service Areas will be involved in the related PIP project.

Patients' Rights Beneficiary Grievances, Appeals and State Fair Hearings

Goal III. 6.
Continue to monitor and improve beneficiary grievances, appeals and State Fair Hearings processes including instituting new electronic system and annual reporting for policy changes.

EVALUATION

This goal has been met.

The Department responds effectively and in a timely manner to consumer grievances and fair practice hearings. The reports were expanded in FY 09-10 to include both inpatient and outpatient beneficiaries, as well as provide additional subcategories.

The Patients' Rights Office (PRO) reported a drop in beneficiary formal complaints from 559 in FY 09-10 to 397 in FY 10-11. Among the 397 formal complaints in FY 10-11, 386 were Grievances, one was an Appeal, and 10 were requested State Fair Hearings. In FY 09-10 among the 559 formal complaints, 539 were Grievances, 5 were Appeals, and 15 were requested State Fair Hearings.

The PRO attributes these decreases to data collection processes that allow for improved problem identification and resolution. At this time, the PRO is acquiring software to enhance its data processing capacity. It is expected that electronic reporting processes will further enhance the PRO ability to monitor and ensure Patient's Rights. The Quality Improvement Division will continue to meet its commitment to monitor beneficiary appeals as well as assist and support the PRO in developing increasingly sensitive and useful measures.

TABLE 32A: NUMBER OF FORMAL COMPLAINTS FROM CONSUMERS - FY 10-11

CATEGORY		Inpatient	Outpatient	Total
ACCESS		**0**	**0**	**0**
	Percent	***0%***	***0%***	***0%***
TERMINATION OF SERVICES		**0**	**6**	**6**
	Percent	***0%***	***100%***	***100%***
DENIED SERVICES (NOA-A Assessment)		**0**	**6**	**6**
	Percent	***0%***	***100%***	***100%***
CHANGE OF PROVIDER		**0**	**3**	**3**
	Percent	***0%***	***100%***	***100%***
QUALITY OF CARE		**288**	**37**	**325**
	Percent	***89%***	***11%***	***100%***
Provider Relations		178	23	201
	Percent	*89%*	*11%*	*100%*
Medication		55	10	65
	Percent	*85%*	*15%*	*100%*
Discharge/Transfer		17	0	17
	Percent	*100%*	*0%*	*100%*
Patient's Rights Materials		2	1	3
	Percent	*67%*	*33%*	*100%*
Treatment Concerns		8	1	9
	Percent	*89%*	*11%*	*100%*
Delayed Services		2	0	2
	Percent	*100%*	*0%*	*100%*
Abuse		18	0	18
	Percent	*100%*	*0%*	*100%*
Referrals		0	0	0
	Percent	*0%*	*0%*	*0%*
Treatment. Disagreement		8	2	10
	Percent	*80%*	*20%*	*100%*
Reduction of Services		0	0	0
	Percent	*0%*	*0%*	*0%*
CONFIDENTIALITY		**7**	**2**	**9**
	Percent	***78%***	***22%***	***100%***
OTHER		**33**	**15**	**48**
	Percent	***69%***	***31%***	***100%***
Housing		3	5	8
	Percent	*38%*	*63%*	*100%*
Lost/Stolen Belongings		5	0	5
	Percent	*100%*	*0%*	*100%*

TABLE 32A: NUMBER OF FORMAL COMPLAINTS FROM CONSUMERS - FY 10-11

CATEGORY		Inpatient	Outpatient	Total
Social Security		0	0	0
	Percent	*0%*	*0%*	*0%*
Unable to Understand		0	0	0
	Percent	*0%*	*0%*	*0%*
Smoking		2	0	2
	Percent	*100%*	*0%*	*100%*
Legal		2	1	3
	Percent	*67%*	*33%*	*100%*
Money/Funding/Billing		4	4	8
	Percent	*50%*	*50%*	*100%*
Use of Phone		3	1	4
	Percent	*75%*	*25%*	*100%*
Forms		0	0	0
	Percent	*0%*	*0%*	*0%*
Medi-cal		0	0	0
	Percent	*0%*	*0%*	*0%*
Miscellaneous (other)		0	6	6
	Percent	*0%*	*100%*	*100%*
TOTALS		**328**	**69**	**397**
	Percent	***83%***	***17%***	***100%***

TABLE 32B: CATEGORIES AND DISPOSITION OF FORMAL COMPLAINTS
FY 10-11

CATEGORY	CATEGORIES					TOTAL	DISPOSITION		
	Grievance	Appeal	Expedited Appeal	State Fair Hearing	Expedited State Fair Hearing		Referred Out	Resolved	Still Pending
ACCESS	0	0	0	0	0	0	0	0	0
PERCENT	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*			
TERMINATION OF SERVICES	4	1	0	1	0	6	0	6	0
PERCENT	*67%*	*17%*	*0%*	*17%*	*0%*	*100%*			
DENIED SERVICES (NOA-A Assessment)	3	0	0	3	0	6	0	6	0
PERCENT	*50%*	*0%*	*0%*	*50%*	*0%*	*100%*			
CHANGE OF PROVIDER	3	0	0	0	0	3	0	3	0
PERCENT	*100%*	*0%*	*0%*	*0%*	*0%*	*100%*			
QUALITY OF CARE	325	0	0	0	0	325	0	325	0
PERCENT	*100%*	*0%*	*0%*	*0%*	*0%*	*100%*			
CONFIDENTIALITY	9	0	0	0	0	9	1	8	0
PERCENT	*100%*	*0%*	*0%*	*0%*	*0%*	*100%*			
OTHER	42	0	0	6	0	48	0	48	0
PERCENT	*88%*	*0%*	*0%*	*13%*	*0%*	*100%*			
TOTALS	386	1	0	10	0	397	1	396	0
PERCENT	*97%*	*0%*	*0%*	*3%*	*0%*	*100%*			

Tables 32A and 32B show number of complaints, types of complaints, and dispositions reported by the Patient Rights Office in FY 10-11.

Goal III. 7.
Continue to improve responsiveness to Beneficiary Change of Provider Requests. Monitor reports on the reasons given by consumers for their change of provider request and integrate measures into new electronic system.

EVALUATION

This goal has been met.

The Patients' Rights Office (PRO) is responsible for collecting the Request to Change Provider Logs submitted by directly-operated and contracted providers in LACDMH. At this time, PRO is acquiring software to track Beneficiary Change of Provider Requests which will further streamline this process.

The Change of Provider Requests were analyzed based on the categories and information from the providers. In FY 09-10, the following categories were developed to capture consumer needs in the following areas: Culture;

Time/Schedule; Service Concerns (treating family member, treatment concerns, medication concerns, lack of assistance); 2nd Opinion Request; Other; No Reason Provided. Table 31 shows the stated reasons by rank order according to frequency for the change of provider request, as well as the percentage of requests approved. In FY 10-11 these categories were further expanded into the Change of Provider Request Reasons as presented below.

TABLE 33: CHANGE OF PROVIDER REQUEST REASONS BY RANK ORDER AND PERCENT APPROVED - FY 10-11

Reason	Number of Requests	Percent Approved
Not A Good Match	200	83.00%
Uncomfortable	172	87.79%
Treatment Concerns	124	90.32%
Other	118	89.83%
Does Not Understand Me	104	78.85%
Lack of Assistance	97	88.66%
Insensitive/Unsympathetic	89	87.64%
Medication Concerns	84	86.90%
Gender	64	91.19%
Not Professional	64	82.81%
No Reason Given	57	80.70%
Language	55	92.73%
Time/Schedule	47	91.49%
Want Previous Provider	29	86.21%
Want 2nd Opinion	27	85.19%
Age	19	78.95%
Treating Family Member	5	100.00%

Table 33 shows number of request for change of provider by rank order and percent approved in FY 10-11.

IV. MONITORING CLINICAL CARE

Goal IV. 1.
Continue to improve medication practices through systematic use of medication protocols and trainings for the use of medication forms and clinical documentation for existing staff and for new staff.

This goal has been met.

LACDMH continues to provide ongoing trainings and information to medical staff regarding best practices and LACDMH established parameters.

Over the past year, LACDMH has focused on establishing policies related to LACDMH psychiatrists' roles and functions in activities related to HWLA. Trainings for psychiatrists about HWLA procedures have been offered.

Consultation parameters defining LACDMH psychiatrists' role with respect to Primary Care physicians have been developed.

In addition, a Clinical Peer Review process has been initiated which is evaluating practices involving patients who are being treated with 5 or more psychotropic medications.

EPSDT PIP

Goal IV. 2.
Continue EPSDT Performance Improvement Project (PIP) to ensure that each consumer receives services that are appropriate, effective and efficient.

EPSDT PIP has been successfully completed on June 30th 2011. During the three years, baseline measures were established and interventions implemented to improve the flow of consumers receiving EPSDT services. A primary goal of this PIP was to expand EPSDT services in need of services who were not receiving them and to effectively transition EPSDT consumers appropriately to more cost effective services. During this time, the number of consumers who spent more than $3,000 in any two months in a fiscal year decreased by 6.1% from 5,310 consumers in FY 09-10 to 4,984 consumers in FY 10-11. From FY 09-10 to FY 10-11, there was an increase of 48.25% (N = 2,608) in the number of EPSDT PIP study cohort consumers receiving EBPs.

From FY 09-10 to FY 10-11 there was an increase of 50.3% in the number of participants trained in EBPs (3,046 to 4,579) and an increase from 26 to 35 EBPs with defined outcome measures for children. Additionally, as an ongoing monitoring activity resulting from this EPSDT PIP, providers are receiving monthly data on consumers that cross the established expenditure threshold. This activity further serves to inform providers of the appropriateness of services and the duration of services. **Table 34** summarizes the results for each performance indicator and measurement for Short Doyle/Medi-Cal and Fee-For-Service providers.

Table 34: Results for Each Performance Indicator and Measurement Period							
Describe performance indicator	**Date of baseline measurement**	**Baseline measurement (numerator/ denominator)**	**Goal for % improvement**	**Intervention applied & dates applied**	**Date of re-measurement**	**Re-measurement Results (numerator/ denominator)**	**Percent improvement achieved**
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							
1.) # of EPSDT clients served with 25% of total EPSDT spending	*July 1, 2009*	*3,657/76,993 4.75%*	*6.75% [from 4.75% to 6.75%]*	*Started July 1, 2010*	*June 30, 2011*	*2,464/77,238 (3.19%)*	*Goal of ≥ 6.75% unmet.*
2.) # of Units of Service (UOS) provided to the clients who spent more than $3,000 in any two months of the year	*July 1, 2009*	*39,654,013/ 117 ,732,196 33.68%*	*25% [from 33.68% to 25%]*	*Started July 1, 2010*	*June 30, 2011*	*49,172,267/1 58,375,241 (31.05%)*	*Goal of ≤25% unmet.*
3.) # of clients who meet the EPSDT PIP Study criteria ($3,000 in any two months of the year)	*July 1, 2009*	*5,310/76,993 6.90%*	*25% [from 35.89% to 25%]*	*Started July 1, 2010*	*June 30, 2011*	*4,984/75,260 (6.62%)*	*Goal of ≤10% met.*
4.) # of daily cumulative claims which exceed 12 hours	*July 1, 2009*	*3,400/662,629 0.51%*	*0.01% [from 0.51% to 0.01%]*	*Started July 1, 2010*	*June 30, 2011*	*3,696/675,11 2 (0.55%)*	*Goal of ≤0.01% unmet.*
5.) # of daily cumulative face-to-face claims which exceed 10 hours	*July 1, 2009*	*28/351,393 0.008%*	*0.003% [from 0.008% to 0.003%]*	*Started July 1, 2010*	*June 30, 2011*	*1,325/579,44 9 (0.23%)*	*Goal of ≤0.003% unmet.*
6.) # of claims for evidence-based practices (EBP)	*July 1, 2010*	*2,175/662,629 0.33%*	*30.00% [from 0.33% to 30.00%]*	*Started July 1, 2010*	*June 30, 2011*	*76,615/675,1 12 (11.35%)*	*Goal of ≥ 30% unmet.*
7.) # of unique clients served in EBPs	*July 1, 2010*	*217/5,310 4.09%*	*45% [from 4.09% to 45%]*	*Started July 1, 2010*	*June 30, 2011*	*2,608/4,984 (52.33%)*	*Goal of ≥ 45% met.*
8.) # of UOS that were EBPs	*July 1, 2010*	*20,921/39,654,013 5.28%*	*30% [from 5.28% to 30%]*	*Started July 1, 2010*	*June 30, 2011*	*5,969,509/49, 172,267 (12.14%)*	*Goal of ≥ 30% unmet.*

Table 34: Results for Each Performance Indicator and Measurement Period							
Describe performance indicator	**Date of baseline measurement**	**Baseline measurement (numerator/ denominator)**	**Goal for % improvement**	**Intervention applied & dates applied**			
9.) # of documentation and compliance training (presentation/announcement)	*July 1, 2010*	*N/A*	*N/A*	*Started July 1, 2010*	*June 30, 2011*	*34*	
10.) # of participants trained in EBPs	*July 1, 2009*	*3,046*	*N/A*	*Started July 1, 2010*	*June 30, 2011*	*4,579*	
11.) # of EBPs with outcome measures	*July 1, 2009*	*26*	*N/A*	*N/A*	*June 30, 2011*	*35 (100%)*	

V. MONITORING CONTINUITY OF CARE

Goal V. 1.

Consumers receiving continuity of care by being seen within 7 calendar days of discharge from an acute psychiatric hospital (Post Hospitalization Outpatient Access – PHOA) and conduct RC2 PIP in collaboration with APS/EQRO and Statewide consultants.

This goal has been met.

The LACDMH utilizes the Post-Hospitalization Outpatient Access (PHOA) indicator as an important measure of continuity of care, critical to preventing repeated hospitalizations and fostering recovery within the community based settings to which consumers return to live, work, and learn. The STATS process monitors and reports performance for this national indicator. At this time, LACDMH directly operated hospitals receive monthly reports highlighting their performance on the PHOA indicator, as well as alerting them to potential data errors, for example possible duplicate consumer entries and discharged cases that have not been closed administratively (for example, lengths of hospitalization exceeding 1 year). This "Report Card" intervention, developed through the RC2 PIP, is expected to further assist Inpatient facilities to monitor and improve service delivery.

Data obtained from the RC2 PIP is presently being used to identify and track high end utilizers of mental health services, as well as formulate contractual obligations with Inpatient Providers regarding timeline requirements for inpatient episode creations and closings.

Please see updated RC2 PIP Roadmap.

VI. MONITORING OF PROVIDER APPEALS

Goal VI.1.
Continue monitoring the rate of zero appeals through CY 2010.

This goal has been met.

LACDMH has successfully maintained the level of provider appeals at zero. In 2011, the state deleted the requirement for First and Second Level Appeals. Contractors have not filed appeals for Day Treatment and TBS authorization over the past four calendar years, for CY 2008 2011. No network provider has filed an appeal of LACDMH psychological testing.

TABLE 35: PROVIDER APPEALS

Level	Day Treatment	TBS Authorization	Network	Total Appeals
2008				
1st and 2nd	0	0	0	0
2009				
1st and 2nd	0	0	0	0
2010				
1st and 2nd	0	0	0	0
2011				
N/A	0	0	0	0

QUALITY IMPROVEMENT WORK PLAN CY 2012

I. MONITORING SERVICE DELIVERY CAPACITY

1. a The Penetration Rate for Latinos below the 200% Federal Poverty Level (FPL) will be maintained at 63.7%.

b. The Retention Rate for Latinos will be maintained at 44.9% for 5-15 services and at 50.6% for 16 or more services.

c. The Penetration Rate for Asian/Pacific Islanders below the 200% Federal Poverty Level (FPL) will be maintained at 44.1%.

d. The Retention Rate for Asian/Pacific Islanders (API) will be maintained at 5.0% for 5-15 services and at 5.4% for 16 or more services.

2. Identify an underserved population in a specific service area and pilot an intervention(s) to increase penetration rates for that population.

II. MONITORING ACCESSIBILITY OF SERVICES

1. Maintain access to after-hours care at 70% of PMRT response time of one hour between PMRT acknowledgements of the call to PMRT arrival on the scene and continue year to year trending.

2. Maintain the rate of abandoned calls (responsiveness of the 24-hour toll free number) at an overall annual rate of 15%.

3. Increase the overall rate by 1% from 88.7% in CY 2010 to 89.7% in CY 2012 for consumers/families reporting that they are able to receive services at convenient locations and continue year to year trending. [Source: Performance Outcomes].

4. Increase the overall rate by 1% from 90.7% in CY 2010 to 91.7% in CY 2012 for consumer/families reporting that they are able to receive services at convenient times and continue year to year trending. [Source: Performance Outcomes].

III. MONITORING BENEFICIARY SATISFACTION

1. Administer the County Performance Outcomes Survey for two weeks in February in collaboration with the Integrated Substance Abuse Program (ISAP) of UCLA to evaluate and improve survey sampling methodology, and continue year to year trending.

2. Increase by 1% from 90% in CY 2010 to 91% in CY 2012 consumers/families reporting that staff were sensitive to cultural/ethnic background [Source: Performance Outcomes].

3. Increase by 1% from 84.4% in CY 2010 to 85.4% in CY 2012 the Overall Satisfaction Percentage Score and initiate year to year trending. [Source: Performance Outcomes]

4. Continue to identify areas for improvement for Service Area QICs for use in quality improvement activities, and increase Service Area Quality Improvement Projects from 2 to 4.

5. Continue to monitor and improve beneficiary grievances, appeals and State Fair Hearings processes, including instituting new electronic system and annual reporting for policy changes.

6. Continue to improve responsiveness to Beneficiary Requests for Change of Provider. Continue to monitor reports on the reasons given by consumers for their change of provider request and integrate measures into the new electronic system.

IV. MONITORING CLINICAL CARE

2. Continue to improve medication practices through systematic use of medication protocols and trainings for the use of medication forms and clinical documentation for existing staff and for new staff.

2. Initiate a Care Integration Collaborative Performance Improvement Project (PIP) to ensure that each consumer receives services that are integrated to address co-occurring disorders (mental health, physical health, and substance abuse).

V. MONITORING CONTINUITY OF CARE

1. Consumers will receive continuity of care by being seen within 7 calendar days of discharge from an acute psychiatric hospital (Post Hospitalization Outpatient Access – PHOA) and continue RC2 PIP in collaboration with APS/EQRO and Statewide consultants. LACDMH Managed Care Division will implement a new intervention to reduce Inpatient Readmission Rates by having staff conduct site visits to hospitals in order to improve continuity of care as well as reporting discharge data to hospitals and outpatient service providers.

VI. MONITORING OF PROVIDER APPEALS

1. Continue monitoring the rate of zero appeals through CY 2012.